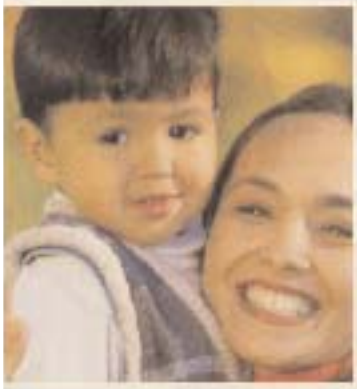
2008 - 2009
State of Georgia
Flexible Benefits Program




TERMS & CONDITIONS

The Flexible Benefits Program is offered by the Employee Benefit Plan Council, the Board of Community Health and participating departments and authorities. The Flexible Benefits Program is governed by the Internal Revenue Code, section 125, and rules issued by the Employee Benefit Plan Council and the Board of Community Health. The Flexible Benefits Program provides you with a method to have your employer purchase benefits with money that would have been paid to you. You do not receive the premium amounts and contributions for the pre-tax options you select as taxable income (and therefore do not pay taxes on that amount); you do receive the benefits as an employer paid benefit. The Option Statement, either paper or electronic, is a binding salary agreement. Failure to comply with all contractual and administrative requirements will result in any excess salary reductions being retained by the Plan. The following statements apply to the benefit options listed on the Option Statement and on the Open Enrollment web site.

1) Your participation in the Flexible Benefits Program is voluntary. You are not required to choose any of the options. If you do not wish to participate in these benefits, mark 'no coverage' in each benefit category, sign and date the paper Option Statement, and return it to your personnel or payroll office. If you choose your benefits through web enrollment, click 'no coverage' in each benefit category and complete the confirmation process.
2) Some coverage levels available to you and the premium amount for each coverage level may be calculated using your retirement salary, your age, your eligibility for disability retirement benefits, and FICA status on your date of hire or the Benefit Calculation Date, which ever is deemed appropriate by the Plan Administrator. Any adjustments to the Benefit Salary, with the exception of errors (as determined by the Plan Administrator) shall be reflected on the following Benefit Calculation Date, to be effective for the following Plan Year. Promotions, demotions, adjustments due to certifications are not deemed to be errors. Any errors in these items should be reported to your personnel or payroll office immediately.
3) The calculation of tax savings does not take into consideration any other income earned by employee or family members, income reduction program such as Deferred Compensation or Tax Sheltered Annuities, or any changes you may make in coverages for the upcoming year.
4) By selecting coverages and indicating contributions to Spending Accounts, you are agreeing that your agency may reduce your taxable income by the amount necessary to purchase those coverages and make those contributions. Except in certain circumstances, the amount of income reduction may not be changed until the next enrollment period.
5) For dependent and/or spousal coverage, it is your responsibility to notify the Flexible Benefits Program if the person ceases to be eligible to participate in the Plan. There will be no refund of premiums paid into the Plan, when a timely change is not made.
6) After this enrollment period you may become a participant or make changes in some coverages only under limited conditions in accordance with the rules of the IRS code, the Employee Benefit Plan Council, and the Board of Community Health. The Employee Benefit Plan Council and the Board of Community Health have the responsibility to interpret these rules and make the final decision as to whether you may enroll or change any coverage outside of the enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered if you submit the proper documentation within the timeframe allotted. To submit a request for enrollment or change to coverage under the State Health Benefit Plan, you must complete and submit a Membership or Discontinuation Form to your employer's Benefits Coordinator within 31 days. Your request for enrollment or a change in any other coverage under the Flexible Benefits Program must be submitted in writing to your employer's Benefits Coordinator within 30 days. Submission of a request for enrollment or a change, or the occurrence of one of the following events, does not guarantee that you will be able to enroll or change coverage outside the enrollment period. Please see your Benefits Coordinator if you have questions about when you may enroll or make changes outside the enrollment period. A list of events that might permit you to enroll or change one or more coverages under the Flexible Benefits Program:

a) You gain or lose a spouse; or
b) You gain (no time limit if due to judgment, decree or order) or lose an eligible dependent; or
c) Your spouse or dependent becomes eligible for or loses coverage under another employer's plan, COBRA or a governmental plan; or
d) An event causes your dependent to gain or lose eligibility for coverage under your employer's plan; or
e) Your change of residence causes you or your spouse or dependents to gain or lose eligibility for coverage under your plan or another employer's plan; or
f) The cost of your dependent care increases or decreases significantly and your dependent provider is not related to you, your spouse, or your dependent; or
g) Your spouse's employer increases, decreases or ceases coverage, or conducts open enrollment; or
h) You, your spouse or your dependent gain or lose eligibility for Medicare or Medicaid.

6) This salary agreement will be terminated if you change the agreement during the next enrollment period. If you do not change the agreement, your benefit choices will rollover in the next Plan year or default to a specified coverage.
8) If you are eligible to participate in the Plan, you terminate and are rehired during the same Plan Year, you must maintain the same options.
9) Options and coverage levels under the State Health Benefit Plan are set forth in the State Health Benefit Plan Document. Options and coverage under the Flexible Spending Accounts are set forth in the Flexible Benefit Plan Document. For all other benefits under the Flexible Benefits Program, the options and coverage levels offered conform to policies provided by the insurance company making the offer. By selecting an option and coverage level you agree to abide by the terms and conditions of that policy.
10) Contributions to Spending Accounts are voluntary. You should not participate in Spending Accounts until you thoroughly read the sections of the Enrollment Booklet related to Spending Accounts. By choosing to contribute money to one or more Spending Accounts you are agreeing to abide by the Rules of the Employee Benefit Plan Council related to Spending Accounts. In particular, you are agreeing to the following provisions:

a) Money contributed for one type of Spending Account cannot be used to pay claims payable from another type of Spending Account.
b) In general, the amount contributed for a Dependent Care Account cannot be greater than the earned salary of you or your spouse, whichever is less.
c) If you are married filing separately, the amount contributed for a Dependent Care Account cannot be greater than $2,500.
d) The validity of a claim against a Spending Account is determined in accordance with the Plan, Internal Revenue Code, and IRS regulations as interpreted by the Administrator subject to the appeal provisions of the Plan.
e) Any money not reimbursable to you will be forfeited to the Flexible Benefits Program. Forfeited money will not be returned or paid to the employee but will be used to reduce the costs associated with providing this benefit.
f) For the Spending Accounts, eligible expenses will be reimbursed in accordance with the Rules of the Employee Benefit Plan Council and the IRS code.
g) For the Dependent Care Spending Account, you will not be reimbursed for more than the Plan has received from your department on your behalf.
h) If you decide to activate and use the Spending Account debit card, you agree to abide by all requirements as indicated in the cardholder agreement received with the card.

11) By selecting the Specified Illness Benefit, you are agreeing to the following:

a) I am asserting that to the best of my knowledge and belief, the answers to the questions on the application are true and complete. They are offered to American General Assurance Company as the basis for any insurance issued. It is understood and agreed that coverage will not become effective unless I am actively at work on the date of enrollment and the effective date of coverage.
b) I understand and agree that no benefits are payable for loss starting or occurring within 12 months of the effective date of coverage which is caused by, contributed to by, due to or resulting from a Pre-existing condition, unless I have gone 12 months without medical care, treatment or supplies for the Pre-existing condition.
c) I realize that any false statement or misrepresentation may result in loss of coverage under the certificate. I understand that no insurance will be in effect until approved by American General Assurance Company and the necessary premium is paid. Any person who, with intent to defraud or knowing that he is facilitating fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.
d) I authorize my employer to deduct the appropriate amount from my earnings and to deduct and pay American General Assurance Company the premium required thereafter each month for my insurance.

12) Other terms and conditions:

a) If you choose not to participate or choose not to continue coverages, your ability to enroll at a later date will be subject to contractual provisions, which may include medical proof of insurability or limited coverages.
b) If you failed to enroll in options requiring medical underwriting when first eligible and you choose new or increased levels of coverage, you must complete the medical underwriting process and be approved.
c) If you choose coverage under the Life Insurance options and the Accidental Death and Dismemberment options, the same Beneficiary Election Form will be used. If a beneficiary is not named, the beneficiary will follow the order stated in the policy.
d) If you select more than $50,000 under the Life Insurance option, you may choose to pay the premium with after-tax dollars to avoid imputed income; this will eliminate any tax savings on the life insurance premium.

13) In the event of an administrative error with respect to the Flexible Benefits Program, decisions will be made in accordance with the Internal Revenue Code, the Rules of the State Health Benefit Plan, and the Rules of the Employee Benefit Plan Council for the Flexible Benefits Program.

Please choose your Plan coverage carefully. Only eligible dependents, as defined by the Plan Administrator and in Program communications, can participate in the Flexible Benefits Program. Any attempt to file claims for a dependent who is not eligible for coverage is fraud. The Plan Administrator will require repayment of any ineligible claims. If the employee purchased family coverage but is only eligible for single coverage, the difference in the premiums paid into the Plan will not be refunded. Also, the difference between single coverage and family coverage premiums will be included as income on a W-2 and/or amended W-2 for inclusion on the employee's tax return. Additionally, the inclusion of ineligible dependents for coverage under the Flexible Benefits Program may result in termination from the Program and/or prosecution for fraud.

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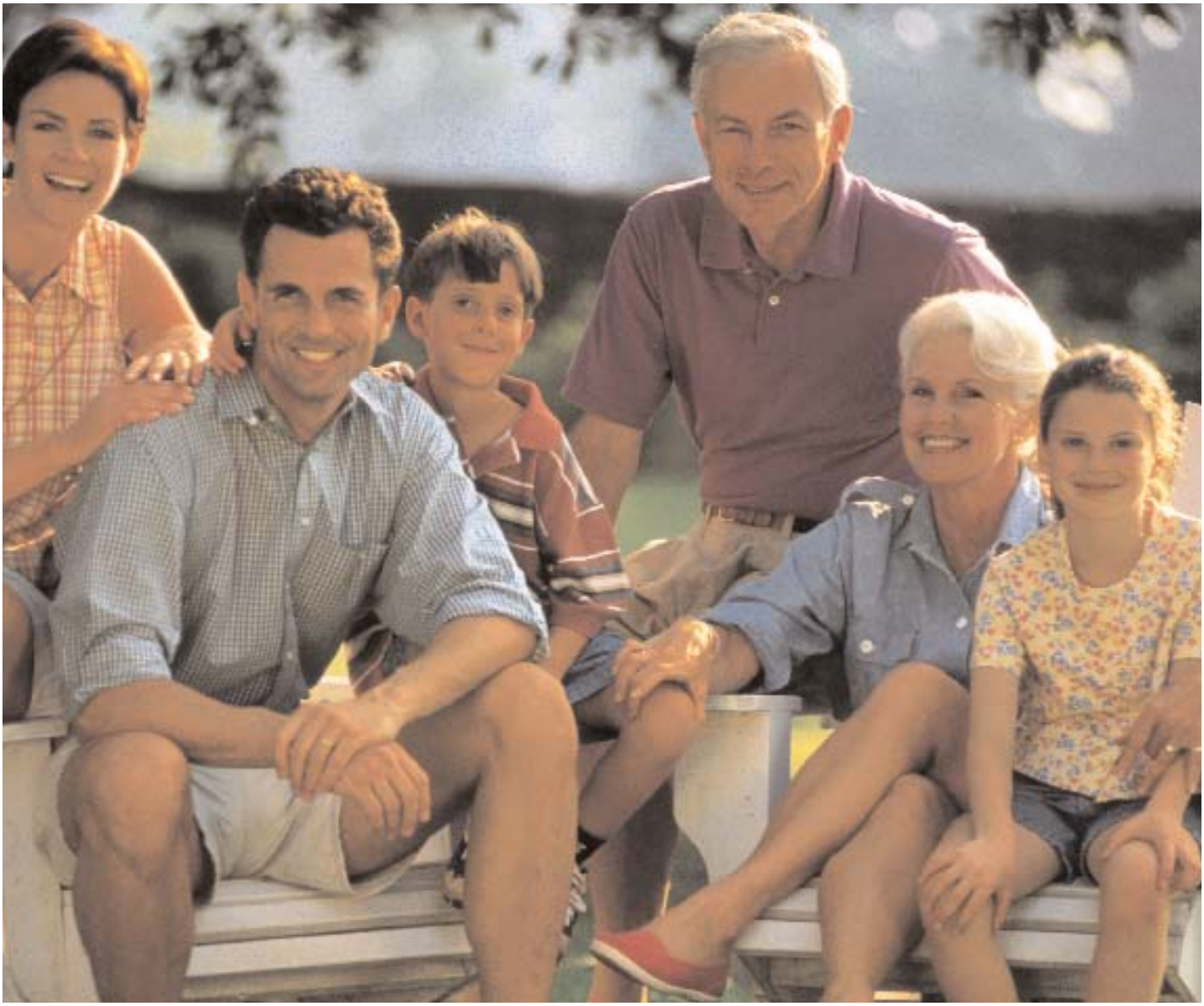


Welcome to the State of Georgia Flexible Benefits Program

Are you planning or expecting the birth or adoption of a child? Getting married soon? Are you caring for an aging parent? Is it time to start thinking about supplementing your retirement? These are just some of life's changes that could affect the health care and financial needs of you and your family.

This 2009 You Decide! booklet gives you an opportunity to review and understand your benefits package. It summarizes benefits available to employees and their dependents eligible to participate in the Flexible Benefits Program, along with certain procedures to be followed to obtain these benefits.

There are some plan enhancements for the 2009 Plan Year, so review all information carefully. It is up to you to understand all the options available and make the choices that best suit your needs. Making the right decisions about your options can make a real difference toward building a rewarding future for you and your family.

WHAT'S NEW!

- All employees will make Electronic Open Enrollment selections through the Team Georgia/Flexible Benefits (TGC/Flex) web site at www.team.georgia.gov/flex during the Open Enrollment period for benefits effective January 1, 2009.
- Employees hired as of July 1, 2008 can select their benefits, complete medical underwriting and select beneficiaries for Life Insurance and/or AD&D on the New Hire Electronic Enrollment site located at www.team.georgia.gov/flex.
- Travel assistance benefit provided to Life insurance participants at no additional cost.
- Beneficiary Management services provided by Minnesota Life for employees to elect, update, and store beneficiary information for Employee Life Insurance and AD&D.
- Current employees may select or increase Specified Illness coverage up to $10,000 without medical underwriting for **this Open Enrollment ONLY!**
- Current employees may select Spousal Specified Illness coverage up to $5,000 without medical underwriting for **this Open Enrollment ONLY!**
- Current employees may select Long-Term Care coverage without medical underwriting for **this Open Enrollment ONLY!**
- 5 new procedures included in the Patient Charge Schedule for the Prepaid Dental option.
- Defendant Civil Action benefit added to the Legal insurance.
- Specified Illness will see a 10% decrease in rates for new participants and a 10% increase in coverage for current participants.
- Short Term Disability will see a 6% decrease in rates for new/current participants.
- Preventive services under the Regular and PPO dental options will be exempt from the $1,000 annual maximum, increasing the amount available for Basic and Major services.
- Effective January 1, 2009 the beneficiary forms for Life Insurance maintained in your department's personnel file will no longer be valid. If you have not designated a beneficiary using Beneficiary Management, any benefit payment will be made according to the schedule stated in the policy.
- **New Name** - Effective immediately, Spectera Vision Plan has a new name, OptumHealth Vision Plan. The benefits are the same, only the name has changed.
- Health Care Spending Account (GPHCSA and LPHCSA) participants will receive new FSA debit cards prior to January 2009, if their card is expiring. The cards will have a new look and carry the name CareWise Health and will continue to be administered by SHPS. If your card does not expire in January, you will receive a new card before it does.
- Dependent Care Spending Account (DCSA) - The IRS has issued clarification regarding the DCSA. Currently, monthly tuition reimbursement requests have been paid if the request occurs at any time during the month of the date of service. The IRS has issued strong warning against this practice. Based on this ruling, DCSA reimbursement requests will only be processed after service has been rendered. SHPS system cannot pend claims for this process; therefore, requests will be denied if submitted prior to services rendered. You may submit claims at end of each week for that week or submit entire amount at end of month.
- Two additional levels (eight (8) and nine (9) times Benefit Salary) have been added to the Employee Life Insurance.
- Employees may qualify for certain levels of Employee Life Insurance without Medical Underwriting. Please refer to the Medical Underwriting chart on page 9 for more detail.

DEADLINE CHANGES

Event	Days to Complete
New Hire Enrollment	30
Qualifying Change of Status Event – Increase/Enroll Coverage	30
Qualifying Change of Status Event – Decrease/Cease Coverage	30

Flexible Benefits Program Calendar

	What to Expect… When
Oct. 1, 2008	All pay-related benefits (employee life insurance, AD&D, and disability) are based on your Benefit Salary and/or Benefit Age on this date.
Oct. 10 - Nov. 10	Open Enrollment period. Mandatory electronic open enrollment. All necessary forms and instructions will be available to you on the Team Goergia web site, www.team.georgia.gov/flex. Confirmation statements prepared, completed, and distributed showing the amount that will be taken from your paycheck beginning in December. Check your Statement carefully to be sure your choices have been recorded correctly. Contact your personnel/payroll office immediately if you discover an error.
Nov. 10, 2008	Your deadline for completing web enrollment and all required forms (including medical underwriting forms).
Dec. 15, 2008	Your first payroll reductions of the new plan year for your health benefit plan premiums and one-half of your monthly spending account contributions. (Note: This date may be different for educational entities.)
Dec. 31, 2008	Your first payroll reductions of the new plan year for premiums for all other Flexible Benefit options and the remaining one-half of your monthly spending account contributions. (Note: This date may be different for educational entities.)
Jan. 1, 2009	Coverage effective date for FLEX… provided you are not absent from work on the first scheduled work day in January due to illness or disability; and have met all contractual and administrative requirements.
Feb. 1, 2009	Notify your personnel/payroll office if you have not received your SHBP ID card or Notice of HMO Membership Action form by this date.
March 15, 2009	Last day to incur eligible expenses for reimbursement from the 2008 General and Limited Purpose Spending Accounts.
May 31, 2009	Deadline for filing Spending Accounts claims incurred during the 2008 Plan Year – January 1 - December 31, 2008. Claims must be postmarked by this date.
Nov. 30, 2009	Last salary reductions for Flexible Benefit premiums for 2009.
Dec. 31, 2009	Last day of coverage for the 2009 plan year, and the last day to incur eligible expenses for reimbursement from the Dependent (Child) Care Spending accounts for the plan year.
May 31, 2010	Deadline for filing Spending Account claims for expenses incurred during the 2009 Plan Year – January 1 - December 31, 2009. Claims must be postmarked by this date.

Who's Eligible To Participate

In general, you are eligible to participate in the Flexible Benefits Program if:

- You are a full-time regular employee who works at least 30 hours a week and are expected to work for at least nine months. Employees who work in a sheltered workshop or work transition program, contingent employees, temporary employees, and student employees are not eligible.
- You are a public schoolteacher, working at least 17.5 hours, and employed in a professionally certified capacity, working half time or more and not considered a "temporary" or "emergency" employee.
- You are an employee of a local school system holding a non-certificated position. You must be eligible to participate in the Teacher's Retirement System (TRS) or its local equivalent, and you must work a minimum of 20 hours a week (or 60% of the time necessary to carry out the duties of the position, if that's more than 20 hours).
- You are an employee of a local school system working at least 15 hours (or 60% of the time necessary to carry out the duties of your position, if that's more than 15 hours) and you are eligible to participate in the Public School Employees' Retirement System (PSERS), as defined by Paragraph 20 of Section 47-4-2 of the Georgia Code.
- You are an employee of a county or regional library and work at least 17.5 hours per week.
- Others deemed eligible by Federal or Georgia law.

If you aren't sure whether you're eligible, contact your personnel/payroll office.

Benefit Salary

Your Benefit Salary includes your base salary and salary supplements that are regular, non-temporary, and not more than the amount on which retirement contributions are calculated - is reflected on your Option Statement and remains constant for the entire Plan year. It is calculated on your date of hire or the Benefit Calculation Date. Any adjustments to the Benefit Salary, with the exception of errors (as determined by the Plan Administrator) shall be reflected on the following Benefit Calculation Date, to be effective for the following Plan Year. Promotions, demotions, adjustments due to certifications are not deemed to be errors. Benefit Salary is the pay used to calculate your pay-based coverage - employee life, AD&D, and disability.

PLEASE NOTE:

Benefit Options Administrative Fees

December 2008 reductions/ deductions for January 1, 2009 coverage will include the 30¢ administrative fee added to each premium with the exception of Health Care Spending Accounts, which has a $2.00 fee per account.

The HSA is subject to a separate fee schedule assessed by the custodian of the account, J.P. Morgan Chase & Co.

Pre-Tax Premiums Help You Stretch Your Dollars

The Flexible Benefits Program allows you to save on taxes while you pay for your benefits. Pre-tax premiums reduce your taxable pay…and your taxes. That's because premiums for most of your insurance options, health benefit options, and spending account contributions are taken out of your paycheck before federal and state income taxes and Social Security (FICA) taxes are withheld.

This means your taxable pay is lower…and so are your taxes. It also means you have more in your paycheck - or more to spend on benefits than you would if you paid the same premiums with after-tax dollars.

The chart below shows the impact of the pre-tax advantage for an employee earning $25,000 a year with annual pre-tax premiums of $1,800.

	with after-tax premiums	with pre-tax premiums
Annual pay	$25,000	$25,000
Annual pre-tax premiums	0	1,800
Taxable pay	$25,000	$23,200
Income and FICA taxes	– 3,513	– 2,997
Annual after-tax premiums	– 1,800	– 0
Take-home pay	$19,687	$20,203

With pre-tax premiums, this employee saves $516 in taxes, and has $516 more to spend on other benefits… or to take home.

• Pre-tax premiums are available only for the state-wide benefits offered through the Flexible Benefits Program; they are not available for other agency-sponsored benefits. This example is based on a married employee filing a joint return and claiming four exemptions.

Age Today	Reduction in Social Security Benefits at Age 65
25	2.6%
35	2.3%
45	1.7%
55	0.8%

Based on pay of $25,000 and $2,500 in pre-tax premiums until age 65.

A Few Words About Pre-Tax Premiums

Using pre-tax premiums will not affect other employee benefits that are based on pay, such as any State of Georgia retirement system, life insurance, disability, and pension benefits. Those benefits will be based on your full pay before pre-tax premiums are taken out. Pre-tax

premiums are not available for short-term disability, spouse life and child life, legal, long-term care insurance or specified illness.

Points To Consider
Whether you're single with no children, single with children, married with no children, or married with children, consider these points if:

Your Spouse Has Benefit Coverage

- **Spending Accounts**
  If your spouse's plan offers spending accounts, you can each have a Health Care Spending Account at the maximum allowed. For Dependent (Child) Care Spending Accounts, however, IRS laws restrict your total family contributions to $5,000 per year. For the 2009 Plan Year (January - December 31) Flexible Benefit Program contributions are limited to $4,992.

- **Health Savings Accounts**
  If your spouse's plan offers spending accounts and your spouse is enrolled in a General Purpose Health Care Flexible Spending Account or another non-HDHP plan, you are deemed 'covered' by a non-qualified Health Plan, and are not eligible to participate in the Health Savings Account.

You Are A New Employee

- **New Hire Electronic Enrollment**
  As an employee hired as of July 1, 2008 you can select your benefits using the New Hire Electronic Enrollment system located on the TGC/Flex web site www.team.georgia.gov/flex.

- **Dental**
  There is a much shorter waiting period in the Regular and PPO options if you sign up immediately. Late enrollment penalties will apply to the Regular and PPO options if you do not enroll now, but elect to do so in the future. The Prepaid Option does not have waiting periods or late enrollment penalties.

- **Spending Accounts**
  Your paycheck reductions for the spending accounts will start the 15th of your first full calendar month of employment. Your total contributions to each account are prorated by the number of months you participate in these options up to the maximum monthly amount allowed for each account.

  Once you enroll, you may submit claims for services incurred on or after the first of the month after you have completed one full calendar month of employment. If, for example, you are hired July 8 and sign up for a spending account, reductions will start on August 15. You can begin submitting claims for services that you incur on or after September 1.

- **Health Savings Account**
  If you elect to participate in the State Health Benefit Plan (SHBP) High Deductible Health Plan, you are eligible to enroll in the Health Savings Account. Unlike other benefit options, premiums for this benefit are not deducted in advance (i.e. your March deduction will cover March health care expenses). To determine your maximum contribution amount, please refer to the Health Savings Account section of this booklet.

- **Long-Term Care**
  You have a one-time opportunity to sign up for long-term care insurance without providing medical underwriting.

  FOR THE PY 2009 OPEN ENROLLMENT PERIOD ONLY - Both current and newly eligible employees may select Long-Term Care with no medical underwriting required.

- **Employee Life, Spouse Life and Child Life**
  You have a one-time opportunity to choose some employee, spouse and child life insurance coverage without providing medical underwriting. The chart on page 9 lists medical underwriting requirements.

  FOR THE PY 2009 OPEN ENROLLMENT PERIOD ONLY - Currently enrolled employees may increase up to possibly 2 levels of coverage to a maximum of $200,000 with no medical underwriting required.

- **Employee Specified Illness and Spousal Specified Illness**
  You have a one-time opportunity to sign up for the Specified Illness guaranteed levels ($5,000 and $10,000) without providing medical underwriting. Coverage for children is included with the Employee benefit.

  FOR THE PY 2009 OPEN ENROLLMENT PERIOD ONLY - Current employees may select up to $10,000 of Specified Illness coverage with no medical underwriting required.

  You have a one-time opportunity to sign up for the Spousal Specified Illness guaranteed level of $5,000 without providing medical underwriting.

  FOR THE PY 2009 OPEN ENROLLMENT PERIOD ONLY - Current employees may select up to $5,000 of Spousal Specified Illness coverage with no medical underwriting required.

- **Disability**
  There is a one-time opportunity to sign up for long-term disability coverage without providing medical underwriting during your new hire eligibility period. If you did not sign up then, you will need to complete an Evidence of Insurability Form.

  There is a one-time opportunity to sign up for short-term disability without being subject to a late entrant waiting period during your new hire eligibility period. If you did not sign up then, you will be subject to the Late Enrollment Penalty.

- **Other Coverage**
  There are no medical underwriting requirements at any time for legal insurance, AD&D, spending accounts, or vision benefits.

Be sure to consider your options carefully when you first enroll. If you decline or drop some of your State coverages and want to pick them up again another year, you may have to prove insurability through medical underwriting to be covered again, or have longer waiting periods to receive full benefits.

When Your Spouse Works For The State

- **Dental**
  Each of you may take single coverage and enroll in different options if you choose, but your children will not be covered. As an alternative, one of you may take family coverage and cover your spouse and children. If you both take family coverage, the most the plan will pay is 100% of the allowable expenses.

- **Spending Accounts**
  - Health Care Spending Account (HCSA) - Each of you may have a Health Care Spending Account for the maximum allowed ($5,040).
  - Limited Purpose Health Care Spending Account (LPHCSA) - If either spouse is enrolled in the Health Savings Account, either or both can enroll only in the LPHCSA.
  - Dependent (Child) Care Spending Account (DCSA) - the family maximum allowed is $4,992.

➢ *If you are married to a State employee covered by the Flexible Benefits Program, make sure you understand how your coverage works together. You may have some advantages.*

- **Health Savings Account**
  If one of you has a General Purpose Health Care Spending Account, neither you nor your spouse can enroll in the Health Savings Account option. The spouse who has the High Deductible Health Plan coverage will be the individual entitled to opening the HSA account and have payroll deductions taken.

- **Long-Term Care**
  Each of you may enroll for the coverage you need.

- If you are married to a State employee covered by the Flexible Benefits Program, make sure you understand how your coverage works together. You may have some advantages.

- **Legal Services Insurance**
  Each of you may take single coverage; in this case, your children will not be covered and some benefits may overlap. Or, one of you may take family coverage, which will cover the spouse and your children. Coordination of Benefit Rules may apply.

- **Employee Life and AD&D**
  Each of you may enroll for the coverage you need.

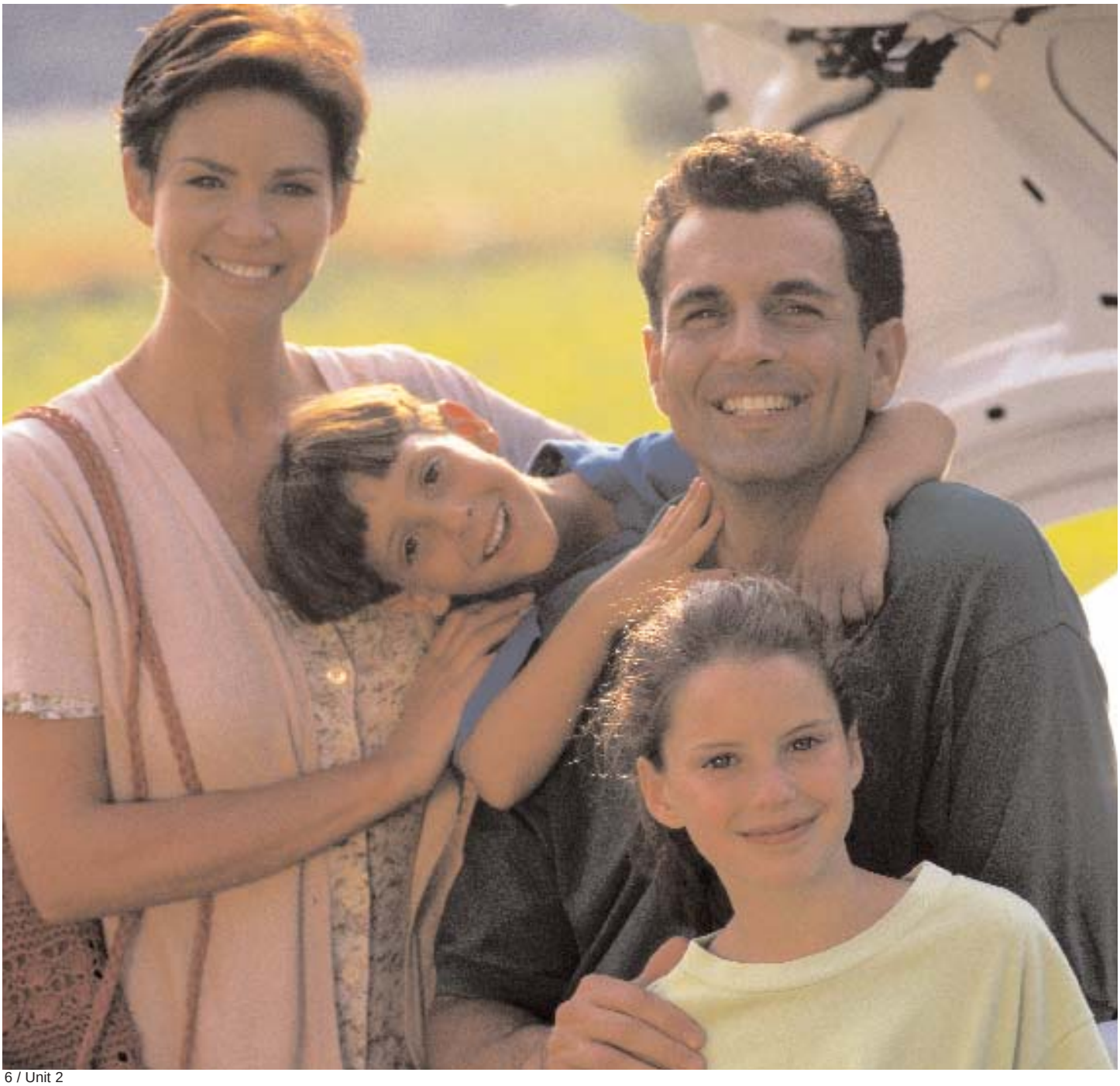
- **Spouse Life**
  Each of you may provide Spouse Life insurance for the other. Or, if you wish, one spouse may take coverage and the other spouse could choose "no coverage."

- **Specified Illness**
  Each of you may enroll for the coverage you need.

- **Child Life**
  Each of you may provide Child Life insurance for your eligible children. Or, if you wish, one spouse may take coverage and the other spouse could choose "no coverage."

- **Disability**
  Each of you may enroll for the coverage you need.

Signing Up For Coverage



Forms to Complete

Depending on the benefit choices made, you may be required to complete additional forms. While some forms can be completed on line, all forms are available to be downloaded at www.team.georgia.gov/flex. Your personnel/payroll office should also have copies of these forms:

- Minnesota Life Evidence of Insurability Form for approval of employee life, spouse life, and child life. If you make any of these benefit selections on the web, you must complete the medical underwriting form on the web.
- Health Savings Account Enrollment Form to be approved for the Health Savings Account. The form must be completed in full and provided to SHPS, Inc.
- AIG American General Evidence of Insurability Form to be approved for specified illness. If you select specified illness on the web, you must complete the medical underwriting form on the web.
- Unum Group Long-Term Care Insurance Application Evidence of Insurability Form to be approved for long-term care coverage. This medical underwriting form is not available on the web. When you have completed the form, return it to your personnel office.
- The Standard Company Evidence of Insurability Form to be approved for long-term disability. If you select long-term disability on the web, you must complete the medical underwriting form on the web.
- CIGNA Prepaid Dental Selection/Dependent form must be completed prior to using this dental benefit.
- United Concordia dependent form should be completed and submitted to United Concordia. You can also find this form at www.ucci.com.
- OptumHealth Vision dependent form should be completed and returned to OptumHealth Vision.

For Dental insurance

If you enroll in the Prepaid Dental Option, you must complete a dentist Selection Form to pre-select a participating dentist prior to being able to use your dental insurance. Be sure to include dependent information on this form. You can call CIGNA's Dental Member Services at 1-800-642-5810 or go online at www.cigna.com to obtain the Dental Selection Form.

If you enroll in the Regular or PPO Dental Option, you will need to complete the dependent form for United Concordia.

Note: Health insurance forms are not applicable to the dental benefit.

For Employee, Spouse, and Child Life Insurance

In addition to your Option Statement or web enrollment, you may be required to complete the life medical underwriting process. If you are a current employee or new employee, the chart on page 9 will assist you in determining medical underwriting requirements.

- **Minnesota Life Evidence of Insurability Form**
  If you or your dependents are required to undergo the employee life, spouse life and child life medical underwriting process, and you enroll electronically, you will be directed to the Minnesota Life LifeBenefit's web site to complete your medical underwriting. You will also designate your beneficiary at this time for Life Insurance. If you complete the paper medical underwriting form, you must submit within 30 days of your hire date. Based on the information you provide on the form, the insurance company may require additional medical information for clarification.

- **Amplified Blood Test**
  In addition to the Minnesota Life Evidence of Insurability Form, your employee and/or spouse life insurance selection may require the completion of an amplified blood test. After Minnesota Life receives your Evidence of Insurability Form, the paramedic company responsible for collecting a blood sample will contact you. The amplified blood test includes measurement of blood pressure, pulse, height, and weight. It may also include an EKG in certain circumstances. You will not be charged for this test. The amplified blood test is never required for child life insurance selections. If you have any questions about the amplified blood test process, please call Minnesota Life toll free at 1-800-660-2519.

  When you request new or additional coverage, and your medical history warrants, the insurance company may ask for additional information, including an amplified blood test. You must complete by the deadline or coverage may be denied.

- **Minnesota Life Insurance Beneficiary Election Form**
  The first time you enroll in employee life insurance coverage, remember to complete the Beneficiary Election Form by accessing the Minnesota Life LifeBenefit web site on TGC/Flex at www.team.georgia.gov/flex. If you are a New Hire electing Life Insurance and you select benefits electronically on the New Hire Electronic Enrollment web site, you will be directed to select a benefit while enrolling. If you desire to make a change, you can update your beneficiary information at TGC/Flex by clicking on the Beneficiary Management link under Life Insurance. You are always the beneficiary of your spouse life and/or child life insurance option.

Effective January 1, 2009 the beneficiary forms for Life Insurance maintained in your department's personnel file will no longer be valid. If you have not designated a beneficiary using Beneficiary Management, any benefit payment will be made according to the schedule stated in the policy.

For Specified Illness Insurance
In addition to your Option Statement or web enrollment, you may be required to complete the medical underwriting process. If you are a current employee or new employee, the chart on this page will assist you in determining medical underwriting requirements.

- **AIG Evidence of Insurability Form**
  If you are required to undergo the specified illness medical underwriting process, you must complete the underwriting process on the web during Open Enrollment. New hires can complete the medical underwriting process when you select your benefits on the New Hire Electronic Enrollment. If you do not select benefits electronically, you must obtain the paper AIG American General Evidence of Insurability Form from your personnel/payroll office or download at www.team.georgia.gov/flex and submit within 30 days.
- **AIG Beneficiary Form**

Specified Illness Medical Underwriting

For Current and New Employees	
Enrolling in Level 1 & 2 ($5,000 & $10,000 coverage)	None
Enrolling in Level 3,4,5, or 6	Medical Underwriting required by the carrier
Enrolling in Spouse Coverage ($5,000)	Medical Underwriting not required this plan year only.

The first time you enroll in Specified Illness, complete the AIG Beneficiary Form and mail it to the address on the form. If you wish to update your information, complete another form and mail it to AIG.

Long-Term Care Insurance
- FOR THE PY 2009 OPEN ENROLLMENT ONLY - current employees may select or increase LTC coverage with no medical underwriting required.
- Outside of the PY 2009 Open Enrollment period, if you are a current employee and wish to choose long-term care for the first time or have discontinued coverage and are re-enrolling or are currently in the plan and wish to increase your benefit level or add options, you must complete the Long-Term Care Application. Call Unum at 1-888-SOG-FLEX (1-888-764-3539) or contact your local personnel/payroll office for an application. The long-term care medical underwriting process cannot be completed on the web.
- If you are a new employee and select this coverage, you do not have to complete this form. Simply, select this coverage on your Option Statement.

For AD&D Insurance
If you have enrolled in life insurance coverage, the beneficiary you name for your life insurance benefits is also the beneficiary for your AD&D benefits. If you did not take life insurance coverage, you designate a beneficiary on TGC/Flex at www.team.georgia.gov/flex. Click on Beneficiary Management under AD&D to complete the Beneficiary Election Form for your AD&D coverage. You can change your beneficiaries any time.

Effective January 1, 2009 the beneficiary forms for AD&D maintained in your department's personnel file will no longer be valid. If you have designated a beneficiary using Beneficiary Management, any benefit payment will be made according to the schedule stated in the policy.

For Long-Term Disability Insurance
If you are a current employee choosing coverage for the first time, or discontinued coverage and/are re-enrolling, you must complete the disability medical underwriting process on the web during Open Enrollment. New hires will complete the medical underwriting on the New Hire Electronic Enrollment site. If you do not enroll electronically, you must obtain the paper form and submit timely.

- **The Standard Company Evidence of Insurability Form**
  The Long-Term Disability medical underwriting process includes the completion of the Evidence of Insurability Form. The form must be completed by the deadline. Based on the information you have provided, the insurance company may require additional medical information for clarification.
- If you are a new employee and select the long-term disability option, you do not have to complete the medical underwriting process.

After you've decided which benefits are best for you, it's time to sign up for them. Refer to the employee checklist on page 48 to assure you are covering all bases.

Additional Required Information
Additional information you may be required to furnish may include medical history questions, medical records from your physician, an amplified blood test, and/or a paramedical examination. There is no additional expense to you for the blood test or for medical records. To speed up the medical underwriting process, you may be contacted by telephone for additional information by The Standard or one of The Standard's representing companies. If you have any questions, please contact The Standard's Medical Underwriting staff toll-free at 1-888-641-7186.

LIFE INSURANCE MEDICAL UNDERWRITING REQUIREMENTS

New Employees Who Choose Coverage	
Amounts	**Medical Underwriting Requirements**
1 X Pay (coverage is capped at $300,000)	None
2, 3, 4, 5, 6, 7, 8, or 9 X Pay (less than $200,000)	None
2, 3, 4, 5, 6, 7, 8, or 9 X Pay (greater than $200,000)	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage $200,000 or more.
Spouse Life: coverage up to and including $30,000	None
Spouse Life: coverage greater than $30,000	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage $150,000 or more.
Child Life: any level of coverage	None

Current Employees Who Choose Coverage	
Amounts	**Medical Underwriting Requirements**
Enrolling for the first time up to 2x Pay under $200,000 (This Open Enrollment **ONLY**)	None
Enrolling for the first time at 2x Pay (over $200,000) or greater of Employee Life OR Discontinued coverage and re-enrolling	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage $200,000 or more.
Currently Enrolled in Employee Life and increasing 1 or 2 levels of coverage up to a maximum of $200,000 (This Open Enrollment **ONLY**)	None
Currently enrolled in Employee Life and increasing 1 or 2 levels of coverage $200,000 or greater, OR increasing to 3 or more levels of coverage.	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage $200,000 or more.
Spouse Life: Enrolling for the first time, re-enrolling, or increasing coverage.	Minnesota Life Evidence of Insurability online Form required. Amplified Blood Test is required for coverage $150,000 or more.
Child Life: Enrolling for the first time, re-enrolling, or increasing coverage.	Minnesota Life Evidence of Insurability online Form required

After You Enroll For Coverage

When Coverage Begins
Coverage for new options selected during the Plan Year 2009 Open Enrollment will begin on January 1, 2009 as long as you have met all contractual and administrative requirements.

Your new premiums for your health benefit plan and spending account reductions begin December 14; other premiums begin December 31 (for semi-monthly pay periods). These dates may not apply if your department has a different pay schedule. Please check with your personnel/payroll office for more information. See specific plan descriptions for information about when your coverage begins.

If you are a new employee, benefit selection (electronic or paper) and all other necessary forms must be completed no later than 30 days after your hire date. Your coverage will begin on the first day of the month after you have completed a full calendar month of continuous employment.

Confirming Your Choices
You are responsible for the benefit selections entered on the Electronic Enrollment site. It is very important that you confirm your selections prior to the end of the enrollment period and ensure that you have a system generated confirmation number. You should print this Confirmation Statement page with the confirmation number to compare with the paper Confirmation Statement you will receive after the enrollment period has ended. The selections should be the same on both Statements. If they do not match, be sure that you are comparing the latest electronic Confirmation Statement. The choices confirmed at the end of the enrollment period are the valid choices. The Confirmation Statement does not guarantee your coverage in some benefit coverages that require additional information. If you have not completed and submitted the additional forms/information required by your selected plan, the choices shown on your Confirmation Statement may not be valid.

Compare your paycheck statements with your Confirmation Statement. It is your responsibility to notify your personnel/payroll office immediately if there is an error. Deductions should match the confirmed choices. Any changes to your benefit selections must be in accordance with IRS §125 and Employee Benefit Plan Council rules and regulations and approved by plan administrators.

If you do not receive a paper Confirmation Statement prior to your first payroll deduction, please contact your personnel/payroll statement immediately.

To Change Your Decisions at Annual Open Enrollment
Every Open Enrollment you can change your benefit decisions, based on which benefits are available and right for you. Remember, this is an annual agreement to allow the State to purchase some benefits for you through pre-tax premiums. You will not be able to change these benefit decisions until the next Open Enrollment unless you have a qualifying change in status as described in the Terms and Conditions.

To Change Your Decisions Outside Annual Open Enrollment

Qualifying Change in Status Event
In general, the Internal Revenue Service prohibits you from changing any coverage elections, or enrolling in or canceling any coverage under the Flexible Benefits Program outside of Open Enrollment. However, the rules of the Internal Revenue Service, the Board of Community Health and the Employee Benefit Plan Council do permit you to change coverage or enroll or cancel coverage in certain limited circumstances, if the change corresponds to a qualifying change in status event*.

Note:** ***Deductions for Health Savings Accounts **(HSAs)** fall outside of this requirement. Please contact your payroll department for details regarding changing your deduction mid-year.

The Employee Benefit Plan Council and the Board of Community Health have the responsibility to interpret these rules and make the final decision as to whether you may enroll or change any coverage outside of the Open Enrollment period. Your request for enrollment or a change outside of the enrollment period will only be considered if you submit the proper documentation within the time frame allotted.

To submit a request for enrollment or changes to coverage under the State Health Benefit Plan, you must submit a completed Membership or Discontinuation Form to your employer's Benefits Coordinator within 30 days of a qualifying event (unless another time period is specified). Your request for enrollment or a change in any other coverage under the Flexible Benefits Program must be submitted on the Change in Status Event Form and given to your employer's Benefits Coordinator within 30 days of a qualifying event (unless another time period is specified). There will be no refund of premiums paid into the Plan, when a timely change is not made.

Submission of a request for enrollment or a change, or the occurrence of a qualifying event, does not guarantee that you will be able to change coverage outside the enrollment period. Please see your Benefits Coordinator if you have questions about when you may enroll or make changes outside the enrollment period. For a list of possible change in status events that might permit you to change one or more coverages under the Flexible Benefits Program, please refer to the Terms and Conditions in the front of this booklet. The changes outlined include dependent eligibility to participate in the Plan. When a dependent or a spouse ceases to be eligible to participate in the Plan, it is the responsibility of the employee to notify the Plan or the vendor.

Generally, any changes will go into effect the first of the month following the date when the payroll deduction is changed to reflect your new choice. For some benefits, however, when you change coverage based on the acquisition of dependents, the coverage effective date for the new coverage may be retroactive to the date of the acquisition of the dependent in some circumstances, or may be the first of the month following the request to change coverage. Please see your Benefits Coordinator for the rules that apply to any specific coverage program.

If you have questions regarding a change in any of your coverages, first call your employer's Benefits Coordinator. If you need further information about eligibility for health coverage, call the State Health Benefit Plan at 404-656-6322 or 1-800-610-1863. For questions regarding other coverages, call the Flexible Benefits Program at 404-656-2730 or 1-888-968-0490.

What Happens If You Leave State Employment*

If you leave State employment, you can continue some of your Flexible Benefits Program choices. Please refer to the chart on page 12.

- You may be eligible to continue your medical, dental, vision coverage and/or Health Care Spending Account (general or limited) for you and eligible family members after your last day of employment through ***COBRA***.
- A conversion or portability feature may apply to your employee life, spouse life, and child life insurance, specified illness, long-term disability and/or AD&D coverage. It is the employee's responsibility to contact the vendors for the conversion or portability of coverage.
- You can be billed and pay directly for legal service insurance (Signature LegalCare) coverage for the rest of the plan year.
- You can continue long-term care. Unum will bill you directly.
- You can convert your Prepaid Dental option coverage to an individual policy and be billed directly by *CIGNA* Dental.
- Your Health Savings Account (HSA) is owned by you, and will continue to exist even after leaving State employment. You will be contacted by the HSA custodian after your departure to request information with how you would like your account to be administered moving forward.

*****It is the responsibility of each employee to contact the vendor directly, within the required timeframe, to continue coverage (see chart on next page), unless you are retiring and wish to continue your dental insurance via your retirement annuity or continue your vision and/or Health Care Spending Account via ***COBRA.*** In these situations, you should contact the Flexible Benefits Program.

If you leave active State employment and then return during the same plan year, your previous choices will remain in effect unless you report a qualifying change in status event.

When you go on leave without pay, contact your personnel/payroll office, the State Health Benefit Plan, and the Flexible Benefits Program. If you do not continue paying premiums for coverage, your benefits will be cancelled and you may be subject to penalties and wait periods, if allowed to re-enroll. You may be required to wait until the next Open Enrollment period to re-enroll. Be sure to review each Plan Description for each option and see your personnel/payroll office for more information.

Taking Coverage With You When You Leave

Benefits	Retiree Coverage Available Through Retirement Plan Benefit Deductions	Coverage Can Be Continued Through COBRA	Coverage Can Be Direct Billed By Carrier, ported or Converted To An Individual Policy	You Must Decide And Complete Forms Within
Dental Coverage • Regular & PPO • Prepaid Option	Yes Yes	Yes Yes	No Yes	COBRA — 60 days Convert 30 Days — Prepaid Option
Vision Coverage	No	Yes	No	60 days
Health Saving Account	No	No	Yes	Contact J. P. Morgan Chase & Co.
General/Limited Health Care Spending Account	No	Yes	No	60 days
Dependent (Child) Care Spending Account	No	No	No	—
Employee/Spouse/ Child Life Insurance	No	No	Yes	30 days
AD&D Insurance	No	No	Yes	30 days
Specified Illness	No	No	Yes	30 days
Disability Coverage Short-Term, Long-Term	No No	No No	No Yes	— 30 days
Legal Insurance	No	No	Yes (through the end of the Plan Year)	30 days
Long-Term Care	No	No	Yes	30 days

Dental

Dental Insurances
Under any of the dental options, single or family coverage is offered. Your cost depends on the option you choose and whether you select single or family coverage. You have a choice of up to three dental options. Due to availability, your best option may depend on where you live or work. For PPO and Prepaid, please check the availability of dentists carefully.

- Regular - For all employees.
- Preferred Provider Option - Specifically for employees who live or work in the metropolitan Atlanta, Augusta, Columbus, Macon, and Savannah areas.
- Prepaid - Specifically for employees who live or work in the metropolitan Atlanta area.

If a PPO dentist or a Prepaid dentist is available in the area where you live or work, you may choose the applicable option. Under the PPO, you have the freedom to go to any dentist, but, there are benefits of using a PPO participating dentist. If your dentist leaves the Prepaid plan during the plan year, you must select another participating dentist.

It is important that you consider your particular needs and be aware of the potential lack of convenience by choosing a dental option that does not have a dental provider in close proximity to where you live. In this case, you will not be able to change or drop your option.

Contact your personnel/payroll representative if you need assistance in choosing the PPO or Prepaid option. Consider the following:

- If you select the Dental PPO and choose to use a non-PPO dentist, you should expect to pay more out of pocket.
- If you select the Dental Prepaid option you must visit a dentist within the CIGNA Dental Care network to receive benefits. You will not receive benefits if you visit a dentist outside the network. You will have limited ability to change dental plans until the following Open Enrollment.

Your Dental Plan Choices (Please review carefully)

Regular Dental Option

- Benefits are determined using the 90th percentile rates for procedures.
- You may use any dentist you choose.
- You may choose a dentist in the available PPO network with benefits based on the maximum allowable charge (MAC). This may result in lower out of pocket costs.
- A non-network dentist is entitled to collect from you the difference between the amount of benefits payable by United Concordia and the dentist charge for that service.

Preferred Provider Option (PPO)

- Benefits are based on the MAC determined by United Concordia and accepted by the PPO dentist.
- Enrollment in the PPO is with the PPO Program, not with a particular dentist. PPO dentists can discontinue their arrangement with the Program at any time.
- If you require the services of a specialist, ask your dentist to refer you to a PPO specialist.
- If you use the services of a non-PPO dentist: The dentist is entitled to charge you the difference between the amount of benefits payable by United Concordia and the dentist's charge. This means you could pay more out-of-pocket expense for using a non-PPO dentist, because the payment will reflect the lower PPO scheduled fee.

Some Important Features Of The Regular and PPO Dental Options
There are some features to keep in mind when you use the dental options, Regular or PPO.

- The options of the State Health Benefit Plan may provide limited coverage for dental treatment. See your SPD, UPDATERs and Health Plan Decision Guide for more information. For more detailed HMO information, contact the HMO directly.
- The PPO dentists have agreed to provide quality services at reduced rates. This means you save money if you use a PPO dentist. If you enroll in the dental PPO, receiving dental care from a non-PPO dentist can result in an increased out-of-pocket expense for you, as shown in the example on the following page.
- United Concordia uses the American Dental Association (ADA) procedure codes in effect at the time a claim is handled to determine benefits.

Pre-Determination of Benefits
Under the Regular and PPO Dental Options, for any service of more than $300, the service should be reviewed by United Concordia before receiving treatment. This is called a "pre-determination of benefits." If treatment occurs without a predetermination of benefits and the service is denied, you may experience unexpected out-of-pocket costs.

Some Exclusions For Regular and PPO Dental Options
Items and services that are not covered by the Regular and PPO Options are set forth in the Summary Plan Description for those options. Some examples include:

- charges for oral hygiene, plaque control programs, and dietary instruction;
- the initial placement of full or partial dentures or bridges, if the prosthesis includes teeth that were missing before you were covered by the dental option.

Six (6) Month Wait Period for Regular and PPO
All New Hires and newly eligible dependents are subject to the Six (6) Month Wait Period for Type III and Orthodontia (dependents under age 19 only) services.

Late Entrant Penalty
Late Entrant Penalty results in delayed benefits in the Regular and PPO plans for up to twenty four (24) months. This means you won't receive some benefits until you have participated in the dental plan for a specified period of time. If you are under the Late Entrant Penalty, you will not be able to receive Type II or Type III services for twelve (12) months and Type III services for twenty four (24) months.

Late Entrant Limitations will apply to:
- current employees who are enrolling in either the Regular or PPO Options for the first time and are not able to present a certificate of continuous coverage with a group dental plan; or
- employees who fail to pay premiums when they are on an unpaid leave, except for FMLA and Military Leave; or.
- current employees who choose not to continue coverage and re-enroll at a later date.

Late Entrant Limitations will not apply:
- if you enroll in the Prepaid Option as a new or current employee*
- when you transfer between the dental options (if not currently under Late Entrant);
- if you enroll in the PPO or Regular Option plan when you are first eligible as a new employee;
- to employees who fail to pay premiums when they are on unpaid Family Medical Leave or Military Leave (if not currently under Late Entrant)
- to current employees who are able to present a certificate of continuous coverage from another group dental plan. Employees will get credit for the amount of valid previous coverage.

New employees are not subject to the Late Entrant Limitations - as long as they enroll when first eligible. If you are a new employee and are interested in the Regular or PPO Options, sign up now to avoid these limitations in the future. Under the Regular and PPO Options, new employees have a six-month waiting period for Major and Orthodontic (dependents under age 19) services.

Differences in the Regular and PPO Benefit Payments

There are differences in the benefits paid by the Regular and PPO Options for the same expense. There are advantages in using a PPO dentist, whether you choose the Regular or PPO dental option.

For example, with a $500 charge, an employee would pay:
- $100 if covered under the Regular Option and using a Non-PPO dentist;
- $35 if covered under the Regular Option, but using a PPO dentist;
- $185 if covered under the PPO Option, but using a non-PPO dentist;
- $35 if covered under the PPO Option and using a PPO Dentist.

So, whether you choose the Regular or PPO option, you save money by using a PPO dentist.

Prepaid Option
If you plan to select or are continuing the Prepaid Dental Option, please read the Patient Charge Schedule carefully, since it has changed.

- The Prepaid option through CIGNA Dental Care is an easy to use plan offering choice, quality, and savings with a focus on preventive care. Choose a general dentist from the CIGNA Dental network. Covered family members can each choose their own dentists, near home, work, or school.
- You will receive a Patient Charge Schedule listing all covered services and the corresponding patient charge for each service. For many services, there is no charge at all. Other plan features include: No deductibles to meet. No annual dollar maximums. No claim forms to file and no waiting periods for coverage.
- If you choose this option, you must select and use a CIGNA Dental Care Participating General Dentist to receive the benefits the option offers. Each family member you enroll may select a personal Participating General Dentist. If your dentist recommends specialty treatment, he/she will refer you to a participating CIGNA Dental Care Specialist. Whether seeing a general dentist or specialist, you will still only be responsible for the fees listed on your Patient Charge Schedule. To estimate costs use the Estimate and Plan for dental costs Dental Treatment Cost Estimator which is a web-based tool that allows enrolled members to estimate and plan for their dental care costs.
- To find a participating CIGNA Dental Care network dentist call 1-800-642-5810 or log onto www.cigna.com.

If a procedure is not listed on your Patient Charge Schedule, it is not covered. A full explanation of plan exclusions and limitations is included in your Patient Charge Schedule.

Some Important Information About the Prepaid Option
- Once enrolled, you will receive a complete Patient

Charge Schedule listing all covered services and associated fees along with your CIGNA Dental Care ID Card. Procedures not listed on the Patient Charge Schedule are not covered.

- You do not need your ID card to receive care. CIGNA Dental will send each dentist a monthly listing of all members who have enrolled with their office. You may request a Patient Charge Schedule by calling CIGNA Dental Member Services at 1-800-642-5810 or online at www.cigna.com, then go to mycigna.com. This Patient Charge Schedule will provide a complete list of covered benefits and co-payments.
- If you choose the Prepaid Option, you must select and use a CIGNA Dental Care Participating Dentist. Otherwise, you will not be eligible for benefits.
- Each enrolled family member may select a different Participating General Dentist.
- To select a CIGNA Dental Care dentist for the first time, fill out and send in the Dentist Selection Form included in your enrollment materials. If you enroll in the CIGNA Dental Care plan but do not choose a dentist, one will be chosen for you based on your zip code. You have the option to change network dentists as often as you like by calling 1-800-642-5810, or by logging onto www.cigna.com. Your change will be effective the first day of the following month.

Did You Know ...

- Your dental benefits are not taxed, and most dental expenses that are not paid by dental coverage - such as deductibles and co-payments - can be submitted to your General Purpose or Limited Purpose Health Care Spending Account, providing a tax savings of 26% - 45% on these expenses.
- Certain Restrictions, along with age and frequency limitations, apply to all dental options. For more information on the Regular and PPO Options, call United Concordia toll free at 1-866-215-2356. For more information on the Prepaid option, call CIGNA at 1-800-642-5810.

Dental Options Comparison Chart

	REGULAR	PPO	PREPAID
TYPE I – PREVENTIVE	100% of the 90th percentile***	100% MAC**	100% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
TYPE II – BASIC	80% of the 90th percentile***	90% MAC**	85% Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges (includes both amalgam (silver) and resin (white) fillings).
TYPE III – MAJOR	50% of the 90th percentile***	50% MAC**	66%* Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ORTHODONTIA	50% of the 90th percentile*** for dependents under 19	50% MAC** for dependents under 19	77% for employee (and eligible dependents*) Reduced, fixed, preset charges for all covered services. See your patient Charge Schedule for Specific Charges
ANNUAL DEDUCTIBLE	$50 per person; $150 for family (applies to Type II and Type III Major services only) each plan year		NONE
MAXIMUM BENEFITS	$1,000 per person each plan year (applies to Type II Basic and Type III Major services only); $1500 lifetime benefit for Orthodontia.		NO MAXIMUM
WAITING PERIOD FOR BENEFITS	New employees or newly enrolled dependents – after six months of continuous coverage for Type III Major services and Orthodontia		NO WAITING PERIOD
LATE ENTRANT LIMITATIONS FOR BENEFITS	Current employees enrolling for coverage for the first time after 12 months continuous coverage for Type II Basic services; after 24 months continuous coverage for Type III Major services and Orthodontia		NO LIMITATION

* Your share of the cost for these services will actually be a flat dollar co-payment. See Schedule of Benefits for details.

TYPE I – PREVENTIVE	TYPE II – BASIC	TYPE III MAJOR	ORTHODONTIA
• Oral exams • Prophylaxis • Space maintainers for dependents under 14 • X-rays	• Fillings • Root canals • Extractions • Scaling and root planing • Repairs to dentures, bridges, and crowns • Sealants, children under 16	• Crowns • Dentures • Bridgework • Surgical periodontal	• Cephalometric x-rays • Treatment study • Bands, appliances

**United Concordia reimburses all fee-for-service and PPO dentists according to the maximum allowable charge (MAC) schedules. The MAC is determined using charge data submitted to United Concordia from more than 100,000 participating providers.
United Concordia policies & procedures and exclusions limitations apply.
This chart is a representative listing of services covered under the program.

***You may use a PPO provider even if you enrolled in the Regular Dental Option.
This may result in lower out-of-pocket costs.

Vision

The Vision Plan, provided through OptumHealth Vision, (formerly Spectera) features:

- covered exams and materials;
- statewide access to a network of panel providers;
- no claims to file for "in-network" benefits; and
- benefits for "out-of-network" providers.

The OptumHealth Vision Care participating provider network includes private practice optometrists, ophthalmologists and retail chains (includes most of the Wal-Mart stores in Georgia). When you make an appointment with a network provider, ensure that they still are participating in OptumHealth Vision network. Then identify yourself as eligible through the State of Georgia Flexible Benefits Program OptumHealth Vision Plan and provide your (employee's) social security number along with the patient's date of birth.

If you receive covered services from a network eye care provider, you will receive the benefits shown in the chart on page 20. You will not be required to file a claim, but will be responsible at the time of service for any co-payments and the cost of any non-covered service or equipment.

If you receive care from an out-of-network provider, you pay the full cost at the time of service and submit a receipt to OptumHealth Vision to be reimbursed for covered out-of-network benefits. Receipts must be submitted together for services and materials purchased on different dates to receive reimbursement. Mail your itemized receipts, with your Social Security number, patient's name and patient's date of birth to:

OptumHealth Vision Claim Department
P.O.Box 30978
Salt Lake City, UT 84130

If you have any questions about your vision care plan option, please contact OptumHealth Vision's customer service at 1-800-638-3120.

***Note: OptumHealth Vision is a name change only for Spectera.**

Important to Remember

- Certain standard contact lenses, including daily wear, and up to 4 boxes of standard single vision disposable contacts are covered in full for your co-payments. If you purchase contacts that are not among OptumHealth Vision's "covered in full" selection, you will receive an annual $105 allowance toward the purchase of contact lenses, and professional fees (i.e., fit and follow-up). Please note: To receive the full $105 allowance, you must receive your exam, fitting and evaluation at a single visit to the same network provider (at Wal-Mart, $70 of the $105 allowance is allocated to materials and $35 to professional fees). The allowance will only apply to one purchase per plan year. You must submit all receipts at the same time. Any balance remaining and not used during the plan year when the purchase occurred will be forfeited.
- Please note: To receive the full $105 allowance, you must receive your exam, fitting and evaluation at a single visit to the same network provider (at Wal-Mart, $70 of the $105 allowance is allocated to materials and $35 to professional fees). The allowance will only apply to one purchase per plan year. You must submit all receipts at the same time. Any balance remaining and not used during the plan year when the purchase occurred will be forfeited.
- OptumHealth Vision covers standard single vision and standard lined multi focal lenses for glasses. Cosmetic lens options such as tinting, UV coating, progressive lenses, etc., are not covered, but are provided to OptumHealth Vision's members at a savings below normal retail charges.
- Always verify coverage by identifying yourself as an OptumHealth member under the State of Georgia plan when making your appointment. Give the provider the employee's social security number, patient's name and the patient's date of birth. Remember to add your dependents to your vision plan by completing the OptumHealth Vision Plan Dependent Form on the TGC/Flex web site.
- Benefits are provided every 12 months for exams, lenses and/or contacts and every 24 months for frames measured from the last date of service. Note: Benefit service limitations are calculated on a rolling calendar year. Example: if you receive exam services in March, you will be eligible to receive another exam in March of the following year.

Medically Necessary**

A member qualifies for medically necessary contact lenses if OptumHealth Vision establishes that an eligible member has any of the following:

- Keratoconus or irregular astigmatism;
- Anisometropia of 3.50 diopters or more;
- Post cataract surgery without intraocular lens; or
- Visual acuity in the better eye of less than 20/70 with spectacles, but better than 20/70 with contacts.

Exclusions

The Vision Plan does not cover:

- replacement of lost lenses or frames
- medical or surgical treatment of eye conditions
- amounts above the schedule of benefits or allowances
- services or materials not included as eligible expenses by the Vision Plan
- cosmetic extras such as no line multifocal lenses, tints, UV coatings etc.

Vision Coverage Chart

Service	In-Network Benefits	Out-of-Network Benefits
Routine Eye Exam Every 12 months	Covered after $10 co-pay	Reimburses up to $40
Lenses Standard Every 12 months, if prescribed	Covered after $20 materials co-pay	
Single vision, or		Reimburses up to $30
Lined Bifocal, or		Reimburses up to $45
Lined Trifocal, or		Reimburses up to $60
Lenticular		Reimburses up to $80
Frames Every 24 months after a $20 materials co-pay*	Retail locations (Wal-Mart) • Up to $130 retail allowance toward any frame package • Frames below $130 provided at no additional cost Private Doctors Office • $50 wholesale allowance towards any frame. You pay the difference. • Group of select frames at no additional cost	Reimburses up to $45 of retail
Contact Lenses Every 12 months in place of eyeglasses		
Medically Necessary**	Covered after $20 materials co-pay	Reimburses up to $200
Not Medically Necessary	Covered after $20 material co-pay for covered lenses selected from OptumHealth Vision's list. Up to four boxes of covered disposable contact lenses are included when using a network provider. All other contacts available through a $105 allowance that includes fitting, follow-up & materials. Please note to recieve the full $105 credit, you must recieve your exam, fitting evaluation and all contact materials at the same provider at the same time. (At Wal-Mart $70 of the $105 allowance is allocated to materials and $35 to professional fees).	Up to $105 max that includes fit, follow-up materials
Refractive Eye Surgery OptumHealth Vision participants receive access to discounted refractive eye surgery from numerous provider locations throughout the United States.	Discount only: The in-network benefit is a discount off the full retail price. To find a participating laser eye surgeon in your area, visit our website at www.myoptumhealthvision.com	No benefits

⦿ Remember: If you use in-network providers, you are responsible only for your portion of cost. If you decide to use a non-network provider, you pay everything and seek the out-of-network benefits payments schedule.

* Only a one time $20 material co-pay applies per benefit period.
**As defined herein (on page 19)

Health Savings Account and Spending Accounts

Health Savings Accounts (HSAs) are tax-exempt savings accounts, and allow you to save for current or future health care expenses. For enrollment in the Flexible Benefits Program, the HSA is available to you if you are:

- enrolled in the State Health Benefit Plan High Deductible Health Plan (HDHP);
- are not enrolled in Medicare;
- are not covered by another health plan; and
- are not claimed as a dependent on someone else's federal tax return.

Through HSA contributions, you can save, invest, and distribute funds on a pre-tax basis for qualified health expenses not otherwise covered by health insurance. While funds in the HSA are not subject to forfeiture and can be carried year to year, the HSA may not be right for all employees in an HDHP. The benefits, as well as the limitations, should be read and understood carefully.

Important features of the HSA:

- Annual maximums:

	HDHP Deductible Deposit (2009)	Maximum HSA
Single Coverage	$1,150	$3,000
Family Coverage	$2,300	$5,950

- Additional contributions can be made through deposits that you or someone else makes directly to the HSA, subject to annual maximums
- Payroll contributions will begin the month in which your account becomes effective, but not before the effective date of your HDHP.
- Payroll contributions for PeopleSoft agencies may be delayed up to 15 days before posting to the account due to the receipt of funds by SPA and the reconciliation process by the TPA and bank.
- Payroll contributions for non-PeopleSoft agencies may be delayed up to a 30-day period before posting to the account due to the receipt of funds by SPA, the manual reconciliation process of payroll and the reconciliation process by the TPA and bank.
- Unlike the General Purpose or Limited Purpose Health Care Spending Account (HCSA), HSA contributions are not accessible for use until the money has been transmitted and posted to the account.
- If you are 55 or older, you may contribute additional dollars up to $1,000 as "catch up" contributions for 2009.
- Rollover amounts from another HSA are not subject to annual contribution limits, and must be deposited within 60 days after receipt of funds. Only one rollover contribution may be made to an HSA during any one-year period.
- Once you reach the investment threshold of $2,000, you may transfer funds into selected investment options offered through J.P. Morgan Chase & Co. A balance must be maintained in your deposit account. If the balance in the account remains $0 for over 60 days, it may be closed due to insufficient funding to pay monthly fees. (Fees may apply).
- Investment transfers, changes in beneficiaries, or changes in contribution amounts can be made at any time during the year.

You will be assessed a $3.00 monthly service charge for the administration of the HSA, which will be directly deducted from your Health Savings Account. If you leave employment with the State, you may retain your HSA, through J.P. Morgan Chase & Co., for a new monthly charge of $5.00. Other applicable transaction fees may apply. See the chart below for detailed HSA fees.

Service	Fee Detail	Fee
Monthly Service Charge	per account per month	$3.00
Debit Card	per card	none
Additional Debit Card	per card	$5.00
Replace Lost or Stolen Debit Card	per request	$15.00
Debit Card Transaction at Merchant Location	per transaction	none
ATM Cash Withdrawals	per transaction	$1.00
Over-the-Counter Teller Withdrawals	per transaction	none
Checks (25 check per book)	per request	none
Additional Checks (25 checks per book)	per request	none
Checking Writing	per check processed	$1.25
Stop-Check Service	per request	$20.00
Duplicate Check	per request	$10.00
Returned Deposit Check or EFT	per returned item	$10.00
Nonsufficient Funds	per transaction	$20.00
Rollover	per account	none
Account Closing	per account	$25.00

IMPORTANT NOTE: Under IRS rules, employees may not participate in a Health Savings Account and a General Purpose Health Care Spending Account (HCSA) at the same time. The General Purpose HCSA is considered a health plan that constitutes "other health coverage," making it impermissible for the employee to make contributions to the HSA.

An individual that participated in the HCSA (employee or spouse of an employee) for the immediate preceding plan year and who is covered by a "grace period," is not eligible to contribute to the HSA until the first day of the first month following the end of the grace period, if there is a balance in the HCSA on December 31st. For example, the Flexible Benefits Program HCSA grace period ends March 15, 2009. If a participant has a balance

in the HCSA on December 31st, and does not elect coverage by a general health care account or other disqualifying coverage for 2009, the employee is eligible for the HSA on April 1, 2009.

If a participant's health care spending account has no unused contributions remaining at the end of the immediate preceding plan year (December 31st), the employee may participate in the HSA and the Limited Purpose Health Care Spending Account.

SPENDING ACCOUNTS

Spending accounts are like getting a tax rebate every time you pay for health care and child or other dependent care expenses, since your pay goes into the accounts before taxes are withheld. This can mean savings of approximately *26%-45%*, depending on your tax situation!

For the 2009 Plan Year, the spending accounts being offered are:

	Limited Purpose Health Care Spending Account (Dental and Vision only	General Purpose Health Care Spending Account	Dependent (Child) Care Spending Account
Annual Maximum	$5,040	$5,040	$4,992
Annual Minimum	$ 120	$ 120	$ 120

- **Limited Purpose Health Care Spending Account (HCSA)**

  The Limited Purpose HCSA has been created specifically for those individuals who are choosing to enroll in the Health Savings Account (HSA) option. Enrollment in the General Purpose HCSA would prevent you from being eligible to participate in the HSA, however, enrolling in the Limited Purpose HCSA will allow you to continue to be deemed eligible to participate in the HSA, allowing you to save tax dollars on the dental and vision treatment you and your family receive.

  The IRS rules and the rules of the Employee Benefit Plan Council designate eligible expenses for the Limited Purpose HCSA. The Employee Benefit Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility. Some of these eligible expenses include:
  - Expenses, deductibles and co-payments not paid by any dental or vision insurance in which you or your family members participate;
  - Costs for procedures not covered or not covered fully by a dental or vision plan;
  - Specialized equipment for disabled persons relating to dental or vision work;
  - Contact lens, glasses, and laser eye surgery;
  - Certain other IRS approved expenses relating to dental or vision work.

Limited Purpose Health Care Spending Account (HCSA) Exclusions List

These are a few examples of health care expenses that are not eligible for reimbursement under the Limited Purpose HCSA:
- Any expense relating to a non-dental or non-vision expense
- Insurance premiums
- Postage/handling fees
- Teeth whitening/bonding
- Vitamins

For further information on potentially eligible expenses, see IRS Publication 502, available at your personnel/payroll office, your local public library or IRS office, or online at www.irs.gov/prod/forms_pubs/pubs/pubs.html. Most, but not all, of the dental and vision expenses are reimbursable under the Limited Purpose HCSA.

- **General Purpose Health Care Spending Account (HCSA)**

  The traditional Health Care Spending Account, or General Purpose Health Care Spending Account (HCSA) helps you save tax dollars on the health-related treatment you and your family receive.
  Like the Limited Purpose HCSA, the IRS rules and the rules of the Employee Benefit Plan Council designate eligible expenses and the Employee Benefit Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility.

  Unlike the Limited Purpose HCSA, the General Purpose HCSA, is not limited to only dental and vision expenses. Some of the eligible expenses for the General Purpose include:
  - Deductibles and co-payments not paid by any health or dental insurance in which you or your family members participate;
  - Costs for procedures not covered or not covered fully by a health, dental or vision plan;
  - Specialized equipment for disabled persons;
  - Preventative care screenings;
  - Contact lens and glasses;
  - Laser eye surgery;
  - Prescription and over-the-counter medicine;
  - Mental health services;
  - Physical therapy; and
  - Certain other IRS approved expenses.

To better understand the differences between the General Purpose HCSA, Limited Purpose HCSA, and the Health Savings Account (HSA), please see the comparison chart below.

Comparison Chart		
General Purpose Health Care Spending Account	Limited Purpose Health Care Spending Account	Health Savings Account (HSA)
Do not have to be enrolled in a HDHP or have health coverage at all	Same as General Purpose HCSA Intended to be used with the HDHP and a Health Savings Account	Must be enrolled in the State Health Benefit Plan (SHBP) High Deductible Health Plan (HDHP)
Distributions cover qualified medical expenses as defined under Section 213 (d) of the Internal Revenue Code	Distributions cover only qualified dental and vision expenses as defined under Section 213 (d) of the Internal Revenue Code	Distributions cover qualified medical expenses as defined under Section 213 (d) of the Internal Revenue Code and certain other expenses (LTC and COBRA premiums)
*Debit Card is available at no charge. Claims can be filed for reimbursement.	*Same as General Purpose HCSA	*Debit Card is available at no charge. If debit card not used, checks are available for a fee. No claims are filed.
The employee funds the account on a pre-tax basis (up to a maximum of $5,040) through monthly election.	Same as General Purpose HCSA	The employee funds the account on a pre-tax basis, up to a maximum of of $1,100 (single) and $2,200 (family) through monthly election and catch up contributions.
The annual amount the employee elects is available on the first day of coverage, regardless of the amount contributed by the date of the reimbursement request.	Same as General Purpose HCSA	Only the amount of the actual account balance is available for reimubursement.
Unused balances are forfeited. Expenses must be incurred by March 15th of the following plan year or by termination of employment, if before the end of the aforementioned benefit period.	Same as General Purpose HCSA	Unused balances are not forfeited and are carried from year to year.
The account cannot be taken with you upon termination, unless the employee is transferring between entities participating in the Flexible Benefits Program.	Same as General Purpose HCSA	The employee owns the account and keeps the account even if he/she changes health plans or terminates/retires.
No investment options available and interest does not accrue.	Same as General Purpose HCSA	Investment options are available with a minimum balance and interest accrues on a tax-free basis.
IRS regulations require that each claim be substatiated.	Same as General Purpose HCSA	Proof of expenses is not required, but the employee should be prepared to substantiate expenses to the IRS upon request.
Limited Changes can be made to contribution amount based on Qualifying Change in Status Event.	Same as General Purpose HCSA	Contribution can be started, stopped or changed at any payroll period on a prospective basis.
No tax forms to submit. Pre-tax amounts are shown on W-2.	Same as General Purpose HCSA	Tax forms 1099 SA and 5498 5A are sent to employee for filing in addition to W-2

**The Debit Card is the same for the Limited or General Purpose Health Care Spending Account (HCSA). If an employee had the General Purpose last Plan Year and enrolls for the Limited or General Purpose HCSA this Plan Year, they should keep the Card and not destroy it. If the Health Savings Account (HSA) is selected, a separate card will be issued. The two cards will be identified by separate colors and headings, "SHPS Flexible Spending Account Card" and "SHPS Health Savings Account Card."*

➢ *2½ Month Grace Period for Limited & General Purpose Health Care Spending Account (HCSA)*
Employees have an additional 2½ months to spend the money in their General or Limited Purpose Health Care Spending Account. This means qualified expenses may be reimbursed for services provided through March 15, 2009. Employees will have until May 31, 2009 to send their claims to SHPS for reimbursement. Remember, if a claim is mailed, the envelope must be postmarked by May 31st. The fastest way to get claims to SHPS is to fax them at 1-866-643-2219.

To best take advantage of this grace period, plan only for expenses you expect to have for the 12 month period. If you do not use all of the money you contributed, you can then use it in the grace period.

➢ *Keeping Receipts*
Remember, for the HCSA (General or Limited) you must keep your receipts since some transactions may require validation by SHPS. For the HSA, proof of expenses is not required, however, you should be prepared to substantiate expenses if requested by the IRS. You must always submit receipts for over-the-counter purchases made with the card.

➢ *Go on-line with MySHPS at http://spendingaccount.shps.com to access web tools, tax savings worksheets, tax savings calculators, claim forms, direct deposit forms, and check your account status. By providing your e-mail address, you may also receive routine correspondence via e-mail from SHPS about your account.*

➢ *Call SHPS AccountLink toll-free at 1-800-893-0763. Use the automated phone system to find out your current account balance(s) and the status of your last claim. You may talk with a SHPS customer service counselor by staying on the line or pressing the (*) key. AccountLink is available 24 hours a day, 7 days a week..*

➢ *Fax Spending Account Claims to 1-866-643-2219. If your email is on file with SHPS, you will receive confirmation of your faxed claim and notification once your claim is processed.*

➢ *The Debit Card*
When you enroll in the Health Savings Account or Health Care Spending Account (Limited or General Purpose) program, you'll receive a VISA® Savings and/or Spending Account Card for purchases of eligible healthcare expenses. You will automatically receive the Card, along with information about the card and how it can be used. You may request up to 4 additional cards with your spouse or dependent's name on it, for a fee of $5.00 per card. If your card is lost or stolen, you may request another card for a fee of $15.00. For additional cards, call SHPS at 1-800-893-0763.

NOTE: If you use your debit card during the grace period, the expenses will be paid from your 2008 HCSA balance. If you have a balance in your 2008 HCSA account, SHPS will perform a "true-up" after May 31st. Once the "true-up" has been completed, SHPS will transfer the funds from your 2009 HCSA balance and you will be able to receive reimbursement for your 2009 expenses. If you have a balance in your prior month's account, it is recommended that, during the grace period, you submit paper claims marked "2008 expenses".

➢ *New HCSA Debit Card - Many participants have Flexible Spending Account Cards that will expire in January 2009. These participants will receive a new card prior to January 2009. Participants with cards that expire at different times will receive new cards prior to the expiration date. These new cards will carry a new look and name, CareWise Health. The program is still administered by SHPS.*

➢ *New Force True Up Process -*

1. *Claim received from participant or Card Swipe occurs.*
2. *Grace period claims should be processed from the prior Plan Year plan if available balance, the processor will utilize the force true-up application. To confirm, the following factors are present with the force true-up application:*
   a. *The true-up application does not look for duplicates.*
   b. *The true-up application does not restrict the transaction code by plan type.*
   c. *The application does consider frozen account status, effective dates, term dates, and previous claims that have spanned the grace period date (3/15).*
3. *The processor selects the Plan Year from which they would like to pay the claim. The default selection is the current Plan Year.*
4. *If no prior Plan Year funds are available, the application will process the grace period claim from the current Plan Year.*
5. *The processor enters the applicable data which includes:*
   a. *Date of Service (DOS)*
   b. *Received Date*
   c. *Type of Service*
   d. *Plan Number*
   e. *They will then verify claim button*
   f. *They will then submit the application should show respective account balances/annual election amounts.*
6. *The application processes the respective amount while debiting prior Plan Year and crediting current Plan Year as appropriate.*

General Purpose Health Care Spending Account (HCSA) Exclusions List

These are a few examples of health care expenses that are not eligible for reimbursement under the General Purpose HCSA:

- Cosmetic procedures/drugs
- Electrolysis
- Hair transplants
- Herbal supplements
- Insurance premiums
- Nicotine patches and gum
- Nutritional supplements
- Postage/handling fees
- Teeth whitening/bonding
- Vitamins

NOTE: You may **not** participate in the General Purpose HCSA and the HSA at the same time.

For further information on potentially eligible expenses, see IRS Publication 502, available at your personnel/payroll office, your local public library or IRS office, or online at www.irs.gov/prod/forms_pubs/pubs/pubs.html. Most, but not all, of these expenses are reimbursable under the General Purpose HCSA.

Dependent (Child) Care Spending Account (DCSA)

The Dependent (Child) Care Spending Account provides you with the opportunity to use tax-free dollars to pay for the care of your **children under age 13 or other IRS eligible dependents** while you and your spouse work or go to school full time.

The IRS rules and Employee Benefit Plan Council rules designate eligible expenses for the Dependent Care Spending Account. The Employee Benefit Plan Council has the responsibility to interpret these rules and make all decisions as to an expense's eligibility.

Please note that the DCSA does not reimburse for any medical expenses. For medical reimbursements for all family members, select the HCSA (General or Limited).

Please note: The IRS has issued clarification regarding the Dependent Care Spending Account (DCSA). Currently, monthly reimbursement requests have been paid if the request occurs at any time during the month of the date of service. The IRS has issued strong warning against this practice. Based on this ruling, DCSA reimbursement requests will only be processed after service has been rendered. SHPS system cannot pend claims for this process; therefore,

requests will be denied if submitted prior to services rendered. You may submit claims at end of each week for that week or submit entire amount at end of month.

Childcare services may include your cost to send a child to preschool, after school, or nursery school. Also, expenses for dependents of any age who are unable to care for themselves because of a physical or mental handicap are eligible. A person qualifying for this type of care must spend at least eight hours a day in your home. Elderly dependent care may include your cost to send a dependent parent to an elderly daycare facility or to have someone to care for them in your home.

If you are married, both you and your spouse must be working or a full-time student during the time the care is received. Your income tax return (long and short forms) will require you to include your dependent care provider's name and tax number or Social Security number.

Dependent (Child) Care Spending Account Exclusions List

These are a few examples of dependent care expenses that are not eligible for reimbursement:

- Activity and book fees
- Child support payments
- Cleaning and cooking services not provided by the care provider
- Custodial nursing care
- Field trips
- Food, clothing, and entertainment
- Late payment fees
- Kindergarten
- Long Term Care premiums
- Overnight camps
- Sports lessons
- Transportation to and from the child care provider
- Tuition to private school

NOTE: *The Economic Growth and Tax Relief Reconciliation Act (EGTRRA) of 2001 increased the amount of the employment-related expenses that may be taken into account for a taxable year to $3,000 for one qualifying individual and $6,000 for two or more qualifying individuals. This increase applies to the Dependent Care Tax Credit only and not the Dependent (Child) Care Spending Account.*

- An employee who is a single parent filing as head of household with one child and $3,000 of dependent care expenses may have better tax savings using the dependent care tax credit instead of participating in the Dependent Care Spending Account.
- The single parent above with one child and more than $3,000 of dependent care expenses may have better tax savings with the Dependent Care Spending Account since the limit is $4992 rather than the $3,000 for the tax credit.
- If there are two or more children with $6,000 in dependent care expenses, the employee could utilize both the dependent care tax credit and spending account by electing $4,992 through the spending account and claiming $1,008 through the tax credit.
- However, the rules for coordinating the dependent care tax credit and spending account do not permit the reverse.

  Example: Assume an employee is a single parent and has $5,000 in dependent care expenses. The employee could not use the $3,000 dependent care tax credit and put $2,000 in the spending account. This would cause the spending account benefit to reduce the expenses eligible for the dependent care tax credit from $3,000 to $1,000 because taking the exclusion under the spending account phases out the dependent care tax credit. You should carefully review your option of using the dependent care tax credit or using the Dependent Care Spending Account.

Everyone's situation is unique - it is very important that you consult a qualified tax advisor for assistance in determining if the dependent care tax credit, spending account, or a combination of the two is best for your situation.

Dependent (Child) Care Spending Account Limits

You may not be able to deposit the full $4,992 if any of the following situations apply to you.

- If your spouse works for the State or another employer who offers a similar plan, the total of your family's contributions to a dependent (child) care spending account cannot exceed $4,992.
- If either you or your spouse earns less than $5,000 a year, you can deposit as much as the smaller of your two incomes.
- If your spouse is either a full-time student or incapable of self-care, you may deposit up to $3,000 for one dependent, or $4,992 for two or more dependents.
- If you are married but file a separate federal income tax return, you may deposit a maximum of $2,500 to your dependent (child) care spending account.
- If you are hired after January 1 or have a qualified change in status during the plan year (see Terms and Conditions in front of this booklet), you may contribute up to $416 per month for the remainder of the plan year.

Important Information About Health Care and Dependent (Child) Care Spending Accounts

There are some important things to keep in mind when deciding how much money to put into your spending accounts.

- If you are hired mid-year or have a qualified change of status during the year (see Terms and Conditions in front of the enrollment booklet), you may not contribute the maximum allowed under each account for the remainder of the plan year. You may only contribute the maximum per month allowed to each account.
- Reductions for spending accounts are made every pay period. But remember to enter the monthly amount you want to contribute on your web Option Statement.

Employee, Spouse and Child Life Insurance and AD&D

Employee Life Insurance
If you want life insurance protection or you want to supplement the protection you already have, you may choose group term life coverage under the Flexible Benefits Program.

You may choose coverage equal to:
•one times your pay (maximum coverage is $300,000)
•two times your pay
•three times your pay
•four times your pay
•five times your pay
•six times your pay
•seven times your pay
•eight times your pay **(NEW!)**
•nine times your pay **(NEW!)**

The coverage maximum is $500,000.

The life insurance amount you choose will be based on your Benefit Salary as of October 1, 2008. This amount is rounded up to the next higher $1,000, after you multiply your coverage and the premium has been adjusted for your October 1, 2008 pay and age. If you are age 65 or older, the value of your life coverage is reduced.

The premium cost for life insurance is based on your age, salary, and on the amount of coverage you choose. You may pay your premiums with pre-tax or after-tax dollars, if you choose coverage over $50,000. If you have over $50,000 of life insurance coverage, it's worth knowing that:
- the extra "value" of your coverage will be shown as "imputed income" on your W2 statement, and you will also pay FICA taxes as well on "imputed income."
- the extra taxes you may owe will be minimal… and the tax savings using pre-tax premiums will be greater than any "imputed income" tax withheld, unless you earn over $100,000 and are over age 65.

In any case, if you elect over $50,000 of coverage you have the option to pay for life insurance with after-tax premiums and avoid imputed income. If you wish to elect after-tax premiums, indicate your choice electronically or on your Option Statement.

How Employee Life Insurance Works
The life insurance amount you choose is paid to your beneficiaries, if you die while this coverage is in effect. Your beneficiaries are the persons you name to receive your life insurance benefits.

If you are choosing life insurance for the first time, designate your beneficiaries by accessing the Minnesota Life LifeBenefit web site on TGC/Flex and clicking on the Beneficiary Management link under Life Insurance. If you are a New Hire electing Life Insurance and you select benefits electronically on the New Hire Electronic Enrollment web site, you will be directed to select a benefit while enrolling. If you desire to make a change, you can also update your beneficiary using the Beneficiary Management link under Life Insurance on TGC/Flex.

Effective January 1, 2009 the beneficiary forms for Life Insurance maintained in your department's personnel file will no longer be valid. If you have not designated a beneficiary using Beneficiary Management, any benefit payment will be made according to the schedule stated in the policy. You may change your beneficiary at any time without the consent of your named beneficiary.

Whenever you enroll or change your life insurance coverage, be sure to check the Life Medical Underwriting process so you will know what will be expected. These processes are described on page 9.

Spouse Life Insurance
If you choose employee life insurance for yourself, you may also choose spouse life insurance coverage for your spouse. Your spouse is eligible for coverage if you are not legally separated or divorced. Spouse life insurance premiums are based on the coverage level and employee age. These premiums for spouse coverage are after-tax. You may choose $6,000, $12,000, $30,000, $60,000,

Attention ERS Pension Plan Members
The Employees' Retirement System of Georgia will be implementing a new retirement plan for state employees hired on or after January 1, 2009. This new plan, the Georgia State Employees' Pension & Savings Plan (GSEPS), will be a combination pension and 401(k) plan with an employer match. Employees covered under the current ERS retirement plan will have the option to transfer their membership to this plan beginning in January. One change with GSEPS is that Life Insurance through the retirement system will not be included in GSEPS retirement membership, as it is now with ERS membership. Therefore, if you are considering transferring your retirement membership to GSEPS, you should also consider obtaining or increasing life insurance through Flexible Benefits during this Open Enrollment period. For more information about GSEPS, visit the Employees' Retirement System of Georgia website at www.ersga.org or call 1-800-805-4609.

$100,000, $150,000, $200,000 or $250,000 spouse coverage levels. However, if you are age 65 or older, the value of your spouse life coverage is reduced.

Spouse Life coverage cannot exceed 100% of your amount of Employee Life coverage.

You are the beneficiary of Spouse Life insurance coverage and will receive the insurance benefit in the event of your spouse's death.

Child Life Insurance
If you choose life insurance for yourself, you may also choose child life insurance coverage for your child(ren). Child life insurance premiums are after-tax. Your children are eligible for coverage if they are unmarried, dependent on you for support and under age 19, or unmarried and a full-time student under age 26.

Points to Remember:
- For the $3,000, $6,000, $10,000, $15,000 or $20,000 child coverage levels, the child coverage can begin at live birth. Coverage from live birth to 6 months is the lesser of the elected amount or $6,000. From 6 months of age to age 19 or 26, the full amount elected applies.
- Child Life coverage cannot exceed 100% of your amount of Employee Life coverage. Physically and/or mentally handicapped children covered under Child Life may continue to be covered beyond the age of 19.
- You are the beneficiary of child life insurance coverage and will receive the insurance benefit in the event of the child's death.

For information regarding conversion and portability of your Employee Life, Spouse Life, and Child Life insurance, contact Minnesota Life Insurance toll-free at 1-800-660-2519.

Enrolling For Coverage
If your coverage selection requires medical underwriting, you will need to complete the Minnesota Life Evidence of Insurability Form along with any other required information. An approval by Minnesota Life, the insurance carrier, must be made before coverage can be in effect.

For Open Enrollment 2009 ONLY! Current employees enrolling in Life Insurance *for the first time* can receive up to 2 times your Benefit Salary (under $200,000) on a guaranteed issue basis with no Medical Underwriting required. Medical Underwriting will be required for coverage over $200,000 OR selecting 3 times your Benefit Salary or greater.

For Open Enrollment 2009 ONLY! Employees *currently enrolled* in Life Insurance can buy up to possibly 2 levels of coverage (under $200,000) without Medical Underwriting. For employees requesting coverage over $200,000, Medical Underwriting will be required. If the employee's requested level is denied, coverage will be reduced to the nearest level of the guaranteed issued amount of $200,000.

NOTE: Employees who have been previously denied will be required to complete Medical Underwriting for any selected level of coverage.

If you are a newly eligible employee, you may elect Employee Life Insurance at one (1) times your Benefit Salary up to $300,000 or Two (2) through Nine (9) times your Benefit Salary up to and including $200,000, $30,000 or less of spouse life coverage and/or any coverage of child life without completing the medical underwriting process.

If you have any questions, call the Flexible Benefits Program at 404-656-2730 or toll free at 1-888-968-0490.

Accidental Death and Dismemberment Insurance
The Flexible Benefits Program lets you decide if you want accidental death and dismemberment (AD&D) insurance.

You may choose coverage equal to:
- one times your pay
- two times your pay
- three times your pay
- four times your pay
- five times your pay
- six times your pay
- seven times your pay

The coverage maximum is $500,000.

In general for the AD&D insurance to be paid to you or your beneficiary, your death or injury must be the result of a covered accident. In case of permanent and total disability, you are eligible for AD&D benefits if your injury prevents you from working at any job for which you are qualified by education, training, or experience.

Enrolling For Coverage
Your cost depends on how much AD&D insurance you choose. As with life insurance, your coverage will be based on your Benefit Salary as of October 1, 2008. This amount is rounded to the next higher $1,000, after you multiply your pay by your election. If you are age 75 or older, the value of your coverage is reduced.

The beneficiaries you name for life insurance are also your beneficiaries for AD&D insurance. If you did not

take life insurance coverage, you designate a beneficiary on TGC/Flex at www.team.georgia.gov/flex. Click on Beneficiary Management under AD&D to complete the Beneficiary Election Form for your AD&D coverage. You can change your beneficiaries any time.

Effective January 1, 2009 the beneficiary forms for Life Insurance maintained in your department's personnel file will no longer be valid. If you have not designated a beneficiary using Beneficiary Management, any benefit payment will be made according to the schedule stated in the policy.

Short and Long Term Disability

To help provide income protection against the unexpected, the Flexible Benefits Program allows you to choose:
• Short-Term Disability insurance and/or
• Long-Term Disability insurance.

Short-Term Disability

If you choose short-term disability (STD) coverage, this plan will work with other income benefits to replace 60% of your Benefit Salary (in effect during the Plan Year the disability began) up to $800 per week. Other benefits include Social Security, workers' compensation, any other governmental disability programs, any other group disability plans including the State retirement systems, or special injury benefits you are eligible to receive. If these other benefits total more than 60% of your Benefit Salary, the short-term disability plan will not pay for this disability.

How STD Works
In general:
- If your claim is approved by the insurance company, you are eligible to receive short-term disability benefits after you have been disabled for 30 continuous calendar days or 7 continuous calendar days depending on the coverage level you have chosen.
- A late enrollment penalty may apply for late entrants to the STD plan (employees who do not elect STD when first eligible).
- You may choose whether to use sick leave or receive these benefits. You cannot receive these benefits and sick leave at the same time. You may, however, decide to receive these benefits and save your sick leave for future use.
- Your STD benefits are calculated on the Benefit Salary that is in effect during the Plan Year your disability began, less other income benefits. For example, if your first day of disability is December 3, 2008, your disability benefit will be calculated on the Benefit Salary reflected on your 2008 Option Statement, not your 2009 Benefit Salary.
- Your STD benefits can continue until you recover, return to work, or receive benefits for a maximum of 150 calendar days or a maximum of 173 calendar days, depending on the coverage level you have chosen. The calendar-day maximums are reduced by any days of paid sick leave, donated leave or Special Injury Leave that you use which exceeds the applicable wait period.
- When changing from the 30-day Benefit Waiting Period to the 7-day Benefit Waiting Period, a Pre-Existing clause is applicable. If you have a condition for which you should have sought medical care or which originated prior to the 7-day Benefit Waiting Period effective date, you will be subject to the rules of the 30-day Benefit Waiting Period until you are on the plan for 12 consecutive months. The Pre-Existing clause does not apply to accidental injuries.

What Is A Late Enrollment Penalty For Late Entrants?

A current employee choosing coverage for the first time or re-enrolling after discontinuing coverage is considered a late entrant. If your STD Disability is caused by an accidental injury, benefits will begin after you have been disabled for 30 continuous calendar days or 7 continuous calendar days depending on the coverage level you have chosen after the benefit waiting period is satisfied for STD. However, for STD late entrants, who become disabled due to Physical Disease, Pregnancy, or Mental Disorder, during the 12-month period after the date your STD insurance becomes effective, benefits will not begin until after you have been disabled for 60 days until you are on the plan for 12 consecutive months. For STD late entrants whose disabilities begin after this 12 month period, benefits will start after the benefit waiting period (7 or 30 continuous calendar days) is satisfied for STD.

Enrolling For Short-Term Disability Coverage
Your premiums will be based on your coverage level and Benefit Salary. Since you pay for this coverage with after-tax premiums, you won't pay taxes on the benefits you receive.

Note: Employees should check with their agency concerning leave usage policies when disabled. Agency policy may impact your eligibility to receive Short-Term Disability benefits.

Long-Term Disability

The Flexible Benefits Program's Long-Term Disability (LTD) coverage works with other benefits you are eligible to receive, including Social Security, workers' compensation, other governmental disability programs, any other group disability plans including the State retirement systems, or any special injury benefits you are eligible to receive. The plan assures that your combined disability benefits from all these sources will equal 60% of your Benefit Salary as shown on your Option Statement, up to $4,000 a month. The plan will pay at least $100 a month, even if your disability benefits from all other sources total more than 60% of your Benefit Salary, up to $4,000 a month, unless you are in an overpayment situation.

How Long LTD Benefits May Be Payable
These benefits will begin after you have been disabled for 180 calendar days and are reduced by any sick leave you use. LTD benefits end when you are no longer disabled or reach age 65, except benefits for disabilities caused by mental disorders, or other limited conditions (excluding schizophrenia, bi-polar or organic brain disease), which are limited to two years. If you become disabled after reaching age 60, however, your benefits could continue for a limited period after age 65.

For the first two years of your disability, you are disabled if you cannot perform your occupation, and earn less than 80% of your monthly Benefit Salary from your employer. After that, you are disabled if you are unable to perform, with reasonable continuity, the material duties of any occupation and cannot earn more than 60% of your monthly Benefit Salary from any employer.

Enrolling For Long-Term Disability Coverage
Your cost for long-term disability coverage is based on your age, your FICA Status, Benefit Salary, and whether or not you are eligible for disability coverage through any State of Georgia retirement plan, and/or through Social Security.

- LTD premiums are paid with pre-tax dollars. The Internal Revenue Service (IRS) considers these benefits to be taxable income.
- If you become disabled and receive LTD benefits, you will be responsible for paying taxes on your benefits from this plan. However, since your income from disability benefits would be lower than your salary, you would owe less in taxes.

If you are selecting LTD insurance for the first time, see page 8 for the medical underwriting process.

Eligibility For An Early Disability Retirement
At total and permanent disability, some employees are eligible for early retirement through a State retirement system, as long as the disability is considered permanent. For the Employees' Retirement System, you may call 404-350-6300 for more information. For the Teachers' Retirement System, you may call 404-352-6500 or toll free at 1-800-352-0650.

If you have any questions about eligibility or how the short-term and long-term disability insurance plans work, call 1-888-641-7186.

Long Term Care

Long-Term Care
Long-Term Care refers to a wide range of personal care, health and social services for people of all ages who suffer a chronic disease or long-lasting disability. These services can be provided in a nursing facility, an adult day care center or at home, and can involve some nursing care. The cost for this kind of care is very high. Home care can be as much as $20,000 per year, and nursing home care can range in cost from $20,000 to $60,000 annually. Generally, you pay these expenses out of your own pocket, because medical insurance and Medicare do not cover long-term care. Typically, Medicaid is only available to members after they have significantly depleted their assets and income. LTC insurance is designed to protect you financially by paying benefits if you need long-term care. It also helps you maintain greater independence and a higher quality of life.

Did You Know…
- Nearly half of all Americans over age 65 require long-term care for some period of time?
- Medical insurance and Medicare generally do not cover long-term care?
- Medicaid covers some types of long-term care, but restricts your choices of where this care can be provided?
- Many Americans will spend their life savings on less than one year of care?

Your Long-Term Care Options
You can choose from one of three daily benefit levels and the corresponding monthly premium that is right for your needs and budget. The amount of the benefit depends on two factors: where the long-term care is provided - either in a nursing facility, or home/day/assisted living facility - and the daily dollar level of the coverage you have selected. With any of these daily benefit options, benefits are paid on a monthly basis. The monthly benefit is equal to 100% of your elected daily benefit amount for care provided in a state-licensed nursing home facility, and 60% of your elected daily benefit amount for care provided in an assisted living facility or at home. If you wish, you can add on a reduced paid-up option and/or an inflation protection option.

Who Can Be Covered
This plan is offered to you, your spouse, your parents or your parents-in-law. "Parents" are biological (natural), adoptive, or step-parents of eligible employees or spouses. Your spouse, parents and parents-in-law will have to complete a medical underwriting process and be approved to be accepted for LTC coverage. Your family members' premiums will be billed directly by the insurance company. Your payroll deduction will be for your individual coverage only.

When Benefits Are Paid
Benefits begin after a 90-day waiting period in which you or a covered family member has an eligible physical or cognitive disability. You qualify for benefits if the disability creates a need for you to receive continual help from another person to carry out any ***three*** of the following six activities of daily living:
- eating
- dressing
- bathing
- using the toilet
- transferring from a bed to a chair
- continence

Benefits from long-term care insurance are not taxed when you receive them.

About Your Premiums and Enrolling
You pay for your LTC coverage through the convenience of payroll deduction with after-tax dollars. Premium costs are based on your age as of the Benefit Calculation Date (October 1). Your family members' premiums are based on their age as of the date they apply for coverage. Their premiums will be sent directly to Unum, not deducted from payroll.

FOR THE PY 2009 OPEN ENROLLMENT ONLY. CURRENT EMPLOYEES MAY SELECT OR INCREASE LTC WITH NO MEDICAL UNDERWRITING REQUIRED. **HOWEVER, IF YOU WERE PREVIOUSLY DECLINED THROUGH UNUM'S MEDICAL UNDERWRITING FOR THE COVERAGE, MEDICAL UNDERWRITING IS REQUIRED.** At all other times, if you are a current employee and selecting LTC insurance for the first time, or are currently enrolled and want to increase your benefit level or add options, or are re-enrolling after discontinuing coverage, check page 9 for medical underwriting requirements. As a newly eligible employee, you may select LTC with no medical underwriting required. For more information about long-term care coverage, call Unum at *1-888-SOG-FLEX (1-888-764-3539).*

The LTC plan can play an important part in your future. Coverage will stay in effect for as long as you continue to pay the monthly premium, even if you should leave the State's employment. You could then apply for coverage continuation and be billed by Unum directly at your home.

Specified Illness

Specified Illness Plan
With the group specified illness plan, our goal is to help you and your family cope with and recover from the financial stress of surviving a critical illness or condition.

According to medical statistics:
- Over 1.3 million new cancer cases were expected to be diagnosed in 2005.[1]
- The National Institutes of Health estimated the overall costs for cancer in the year 2004 at $189.8 billion: $69.4 billion for direct medical costs and $120.4 billion for indirect costs.[1]
- An estimated 700,000 Americans were to have a new coronary attack in 2005. About 500,000 were to have a recurrent attack.[2]
  It was estimated that a stroke occurred every 45 seconds in 2005.
- The estimated direct and indirect cost of cardiovascular disease was $393.5 billion in 2005.[2]

The good news is that many people with a specified illness survive these life-threatening battles. Unfortunately, as the recovery process begins, people become aware of the medical bills that have piled up. Your recovery doesn't have to be spoiled by medical bills.

Plan Provisions
Employee coverage levels:
- $5,000 - No Medical Underwriting required for 2009 Plan Year
- $10,000 - No Medical Underwriting required for 2009 Plan Year
- $20,000 - Medical Underwriting required
- $30,000 - Medical Underwriting required
- $40,000 - Medical Underwriting required
- $50,000 - Medical Underwriting required
- Lump-sum benefits paid directly to the insured following the diagnosis of each covered specified illness after you are hospital confined for the specified illness and charged for room and board. (See the chart on page 39 for information on covered specified illnesses.)
- Rates cannot be individually increased due to change in age, health or individual claim.
- Simplified underwriting-answer only a few health questions.
- The plan is portable* - take your coverage with you if you leave your job.
- Available to employees age 18-69.
- Benefits for participants reduced 50% at age 70.

Spouse coverage levels:
- $5,000 benefit - No Medical Underwriting required for 2009 Plan Year
- Same plan design as employee
- Employee must have coverage for the spouse to have coverage
- Rates are based on employee age

Child coverage:
- Children covered at no additional cost
- All children are covered at 10% of employee benefit amount
- Children ages 0 - 24, if a dependent
- Child coverage automatically added to existing employee coverage

Definition of Medical Underwriting :
- No Physical or Test

- **The questions below must be answered for amounts exceeding $10,000**
  1. Is any person to be insured now being treated for or has any person ever been treated for:
  > cancer or any malignancy which includes: melanoma, carcinoma, sarcoma, Hodgkin's Disease, leukemia, lymphoma, or malignant tumor. (Cancer does not include basal cell or squamous cell carcinoma);
  > a stroke, a heart attack, a heart condition, heart trouble, or any abnormality of the heart (including artery disease);
  > diabetes, or any liver disorder;
  > kidney (renal) disease;
  > organ transplant; emphysema;
  > now taking three or more medications for high blood pressure?
  2. Has any person to be insured been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or "AIDS" Related Complex (ARC), or ever been tested positive for antigens or antibodies to an "AIDS" virus?
  3. Is any person to be insured now hospitalized or unable to perform their normal duties and activities?

First Occurrence Benefit
After the Waiting Period, an insured may receive up to 100% of the benefit selected upon the first diagnosis of each covered critical illness.

Additional Occurrence Benefit
If an insured collects full benefits for a Critical Illness under the plan and later has one of the remaining covered illnesses, then we will pay the full benefit amount for any additional illness. Occurrences must be separated by at least 6 months.

Re-Occurrence Benefit
If an insured receives full benefit for a covered condition and is later diagnosed with the same condition, we will pay the full benefit again. The two dates of diagnosis must be separated by at least 12 months or 12 months

treatment free for Internal Cancer.

Health Screening Benefits

An insured may receive a maximum of $50 for any one covered screening test per calendar year. We will pay this benefit regardless of the results of the test. Payment of this benefit will not reduce the amount payable for the diagnosis of a critical illness. There is no limit to the number of years the insured can receive the health screening benefit; it will be paid as long as the policy remains in force. This benefit is payable for the covered employee. The covered health screening tests include:

- Stress test on a bicycle or treadmill
- Fasting blood glucose test, blood test for triglycerides or serum cholesterol test to determine level of HDL and LDL
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest x-ray
- Colonoscopy
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- Pap smear
- PSA (blood test for prostate cancer)
- Serum protein electrophoresis (blood test for myeloma)
- Thermography

Covered Critical Illnesses*	
Illnesses Covered Under Plan	Percentage of Face Amount
Heart Attack	100%
Stroke	100%
Major Organ Transplant	100%
Renal Failure (End Stage)	100%
Internal Cancer	100%
Carcinoma in situ**	25%
Coronary Artery	25%

*Certain stipulations apply to portability.

**A partial benefit (25%) is payable for carcinoma in situ and coronary artery bypass surgery. Payment of the partial benefit for carcinoma in situ will reduce the benefit for internal cancer. Payment of the partial benefit for coronary artery bypass surgery will reduce the benefit for a heart attack.

1. 2005 Cancer Facts & Figures, American Cancer Society

2. 2005 Heart and Stroke Statistical Update, American Heart Association

Legal Insurance

Legal Insurance
Everyday occurrences often require legal assistance, whether it's selling a home, establishing a will, defending a traffic ticket, or addressing a variety of other legal matters. Attorney fees can be costly, ranging from hundreds to thousands of dollars.

A recent study has shown that, in any given year, workers are 3 times more likely to be involved in a legal dispute than to be admitted to a hospital and 88% of workers surveyed experienced at least one legal event in a year.

The State of Georgia Flexible Benefits Program has offered the benefits of group legal services insurance for over 15 years. During that time, thousands of employees from the State of Georgia have taken advantage of this valuable resource and have been better able to afford qualified legal advice.

Legal advice is a need felt by all segments of the population and it is growing every year. It is for this very reason the value of a group legal services insurance plan is increasingly being recognized as one of the most helpful and responsible benefits of the decade.

Signature LegalCare® is proud to be a part of the GE Consumer Finance portfolio of products. With Signature LegalCare®, you have the freedom and flexibility to deal with debt collection defense, adoptions, divorce, wills, estate administration, and more. Experienced Participating Attorneys can answer many of your questions over the phone.

Additional Services

Telephone Advice. This benefit provides the opportunity for a Covered Person to discuss with an Attorney personal legal problems that are not specifically excluded under the Plan. The Attorney will explain the Covered Person's rights, point out his or her options, and, if needed, recommend a course of action. This service is available from Participating Attorneys located in any state. In addition, a Participating Attorney located in Georgia will make follow-up calls and send correspondence to third parties and will review simple legal documents. This service is available through an independent law firm referred to as the Preventive LegalCare Office (PLCO). The Covered Person will not be billed for this service, there is no limit to how often the service is used, and there are no claim forms to be completed.

Reduced Fee Benefit. For legal fees that are not otherwise covered by the Plan (e.g., the Covered Person's "Attorney Office Work" benefit is exhausted or the matter is not a paid-in-full benefit and the attorney fees have exceeded the Plan's maximum benefit amount), a Participating Attorney who elects to provide this benefit will charge his/her fees at a rate at least twenty five percent (25%) less than his/her usual and customary rate ("UCR"). Plan exclusions apply.

Maximum Contingent Fee Benefit. For any matter that is not otherwise covered by the Plan and for which a Participating Attorney who elects to provide this benefit normally charges a contingent fee (common for personal injury claims and other matters for which a Covered Person as a plaintiff anticipates being paid or awarded a large sum of money), the Participating Attorney will charge no more than the following maximum percentages:

- twenty five percent (25%) for all activities up to and including initial trial or settlement (including consultation and review)
- thirty percent (30%) for all activities relating to the appeal of an initial judgment, including appellate hearing and settlement

These limits apply to the attorney's fees, only, not to other costs not normally included as part of the Participating Attorney's professional fees. Plan exclusions apply.

Personal Law Center. The Personal Law Center is an online resource that is accessible through the Signature LegalCare Web site. It provides Covered Persons with unrestricted online access to a library of plain-English and easy-to-use legal and financial information, self-help forms, and interactive documents and tools.

In-Office Legal Services

The Signature LegalCare® plan makes in-office attorney visits easy! A Participating Attorney will provide you with advice on most covered legal matters with attorney fees paid-in-full. If there isn't a Participating Attorney in your area, Signature LegalCare will cover the services of a Non-Participating Attorney on the same basis as for services provided by a Participating Attorney.

You may also choose to see a Non-Participating Attorney of your choice. For services provided by a Non-Participating Attorney, the Plan will reimburse you at a rate of $17.50 per quarter hour up to a maximum benefit amount. You are responsible for the balance of the attorney's fees. When covered services have been completed, file a claim form, including your attorney's billing statement, with Signature LegalCare. You'll receive direct reimbursement for the attorney's services, up to the maximum allowed by the Plan.

The Plan includes benefits for the following services:

- **NEW!** Defendant Civil Action Benefit
- Administrative Hearings
- Adoptions
- Attorney Office Work (see "Note", below)
- Child Custody/Child Support
- Consumer Protection
- Debt Collection Defense
- Document Review and Preparation
- Estate Administration and Estate Closing
- Eviction Defense
- Guardianship/Conservatorship
- Immigration/Naturalization
- Internal Revenue Service Audit
- Juvenile Court Proceeding
- Matrimonial Matters
- Name Change
- Real Estate Matters
- Traffic Charges
- Wills and Trusts

NOTES:

NEW! Defendant Civil Action Benefit has been added. This benefit is defined as, *"Legal services required for a Covered Person as defendant after court action has been initiated in a civil damage suit, either personal or real, not involving debt collection, claims arising out of vehicular or boat accidents, or claims that are covered by other insurance."*

You will have eight hours each year available to you under the "Attorney Office Work" benefit to use towards legal advice for non-covered services (except those legal matters which are specifically excluded).

For additional information on Signature LegalCare® benefits or if you have questions concerning how the legal services insurance plan works, you may call Signature LegalCare® at 1-800-848-2012 or visit their web site at www.SignatureLegalCare.com. Scroll down to State of Georgia and enter your 5-digit password (43215).

Electronic Open Enrollment

New web address!
New on-line instructions!
New Help Desk telephone number!

Please read the information below carefully:

Employees can sign on to the Team Georgia web site at **www.team.georgia.gov/flex** to select their Flexible Benefits options. Links are provided to access the Flexible Benefits Open Enrollment site and the State Health Benefit Plan's (SHBP) Open Enrollment site. Employees will also be able to access the SHBP Open Enrollment site directly at **www.oe2009.ga.gov.**

During the Fall Open Enrollment for Plan Year 2009 (coverage period January 1 - December 31, 2009), on-line enrollment is mandatory for all eligible employees who participate in the State of Georgia Flexible Benefits Program, including those hired between September 1 through November 1, 2008 (Note: Special instructions will be provided on-line if the new hire information is not available for the selection of the health benefit option). Employees must select their Flexible Benefits electronically by accessing the Team Georgia web site. See SPA web site at www.spa.ga.gov for available Internet locations if you don't have access at work, home or another location.

The menu design enables you to click on the option, review your available benefit choices and submit your selections on-line. The Summary of Your Selections 2009 page provides a summary of your Open Enrollment selections; the Summary of Your Selections 2008 page lists the options in which you are currently enrolled (excluding health benefit).

Before making your selections, carefully review your 2009 You Decide! booklet, including "Terms and Conditions" of your enrollment, the What's New in Plan Year 2009 brochure and the 2009 State Health Benefit Plan Decision Guide. Entry of your selected options indicates that you agree to the Terms and Conditions and understand this is a binding salary agreement for the duration of the 2009 Plan Year with the exception of the Health Savings Account (HSA). No changes can be made except under limited conditions when you have a qualifying change in status event. For the Health Savings Account (HSA), changes can be made at anytime, on a prospective basis only.

WEB ON-LINE INSTRUCTION
Open Enrollment 2009

Open Enrollment 2009
Fri., October 10 - Sun., November 9, 2008
4:00 a.m. - midnight

Monday, November 10, 2008
4:00 a.m. - 4:30 p.m.

Web Navigation Help Desk
Atlanta Metro: 404-656-3000
Toll Free: 1-800-264-3941
7:00 a.m. - 5:00 p.m.
(excluding weekends and holiday)

GOING ON-LINE

- Go on-line using your regular Internet browser (recommended Internet Explorer 6.0 or higher).
- Employees can access the Electronic Open Enrollment web site address at: *www.team.georgia.gov/flex*
- Click on the "GO" button for 2009 Flexible Benefits Enrollment
- Click on the "GO" button for 2009 Health Benefits Enrollment

INITIAL SIGN-ON
ALL employees MUST REGISTER prior to first time login for Plan Year 2009 Open Enrollment.

- Type in your USER ID (Your social security number without the dashes).
- Enter the following information:
  - Password (Create a password you can remember with a length from 6 to 8 characters. The password is case sensitive so remember how you type it).
  - Repeat password (Re-enter the password you just created).
  - Date of Birth. Click the drop down for your month and day. Type your year of birth (yyyy).
  - Select a security question. Click the drop-down arrow to see the choice of questions.
  - Answer the question (this will allow you to reset your password at a later date should you forget it).
- Click the REGISTER button.

Before making your selections, review the personal data for accuracy. Notify your personnel/payroll office immediately if this information is incorrect, because some premiums are calculated based on this information (i.e. age, benefit salary).

If an error is found, check the web site regularly to determine if updates to your personal data have occurred. You can, however, proceed with viewing the web site

even though some information may be incorrect.

NOTE: Please select your benefits, prior to the deadline, as they appear on screen. If the base information is still incorrect on the web site at the end of Open Enrollment and a discrepancy occurs (as determined by the Flexible Benefits Program) in coverage or premium due to incorrect information, a correction can be approved.

You are now ready to review and submit your choices on-line. Click the Continue To Next Page button to view your 2008 benefit options.

SELECTING YOUR OPTIONS

Before making your selections, carefully review the Terms and Conditions of your enrollment located in your You Decide! booklet.

Select options in any order you wish. However, there are some exceptions:
- It is necessary to have the Employee Life option before you can select the Spouse Life and/or Child Life option(s).
- It is necessary to have the High Deductible Health Plan before you can select the Health Savings Account (HSA).
- You cannot enroll in both the General Purpose Health Care Spending Account AND the Health Savings Account (HSA).
- It is necessary to have the Employee Specified Critical Illness option before you can select the Spouse Specified Critical Illness option.
- You must complete the medical underwriting section for options requiring medical underwriting (**).

To select an option:
- Click the option in the menu selection on the left side of the page or in the Flexible Benefit Option column in the Summary of Your Selections 2009 box.
- Click the radio button next to the coverage choice except for the Spending Accounts and Health Savings Account options. Please enter MONTHLY amount or "00" for the Spending Account and Health Savings Account options.
- Click the SUBMIT YOUR SELECTION button each time you make a benefit selection. Each time you click the SUBMIT YOUR SELECTION button you will be taken back to the Summary of Your Selections 2009 page, except when selecting options that require medical underwriting (**).

(**) See the Special Instructions section for additional entry instructions.

CONFIRMATION PROCESS
- Once you have completed your selections for Flexible Benefits, click the CONFIRM button on the Summary of Your Selections 2009 page.
- Check the box acknowledging you have read and abide by the Terms and Conditions of enrollment.
- If you are not ready to confirm your benefit selections, click the Cancel (I will confirm later) button.
- If you are ready to confirm your benefit selections, click the Please Confirm My Benefit Choices.
- You will be taken back to the Summary of Your Choices 2009 page. A unique confirmation number, date and time will be displayed. Print the confirmation page or write down the confirmation number, date and time for your records.
- If you want to change your selection after confirming on the web site, you may return to the web site as often as you like during the Open Enrollment period to make changes. Each time you complete the final confirm process a new unique confirmation number will be created. The benefits selected as of 4:30 pm Monday, November 10, 2008 will be your final selections.

CONFIRMATION NUMBERS
Your selections are not final until you complete the confirmation process. Print the confirmation page or write down the confirmation number, date and time for your records.

LOG OFF
- Click Log Off when you have completed your visit to the web site. You may sign on again throughout the Open Enrollment period - October 10 - November 10, 2008.

SUBSEQUENT SIGN-ON
- Enter your Policy Number (ssn without dashes).
- Enter your password.
- Click the Login button.

FORGOT YOUR PASSWORD?
- Click I FORGOT MY PASSWORD.
- Answer the security question.
- Create a new password (create a password you can remember with a length from 6 to 8 characters).

(**) SPECIAL INSTRUCTIONS
- Medical Underwriting
  - If you select Employee Life, Spouse Life, Child Life, Long-Term Disability and/or Employee Specified Critical Illness option(s) requiring medical underwriting, you will automatically be taken to a page to complete the form on-line. See instructions on the web site to complete the medical underwriting form(s) online.

- You must complete the medical underwriting process for Employee Life, Spouse Life, Child Life, Long-Term Disability and/or Employee Specified Critical Illness on-line in order to complete the final confirmation process. You may click the "Finish Later" button to save your entry and return to the web application to finish no later than the last day of Open Enrollment.
- If you do not wish to complete the medical underwriting form on-line, you will need to change your selection to one that does not require medical underwriting.

OTHER

- You may not select a coverage level in either the Spouse Life and/or Child Life options that exceeds your amount of Employee Life coverage.
- Employee Life After-Tax - If you select over $50,000 of Employee Life coverage, you may choose to pay with after tax dollars by clicking the box in the after tax section on the Employee Life page.
- You may not select the Health Savings Account (HSA) if you have not selected the High Deductible Health option.

The Path2College 529 Plan
Offered by the Georgia Higher Education Savings Plan

Start your child on the path to a brighter future.
There are a number of paths to choose from to pay for a child's education. Choose the right one, and virtually any college dream can be within reach. And college can lead to a brighter future. Even if your child receives a HOPE Scholarship or other forms of financial aid, saving for college now is a key step to avoiding loans and providing flexibility down the road.

Now, thanks to a program offered by the State of Georgia - the Path2College 529 Plan, formerly referred to as the Georgia Higher Education Savings Plan (GHESP) - you have a smart and flexible way to help save for future higher education expenses.

With a Path2College 529 Plan account, you don't pay Georgia or federal taxes on earnings as your account grows. Then, when it's time to pay for college, the money you withdraw for qualified higher education expenses is also Georgia and federal tax-free. In addition, Georgia offers a state income tax deduction for up to $2,000 in contributions for each beneficiary.

With the Path2College 529 Plan, you can choose from seven investment options designed to meet your savings goals. There are no start-up or application fees, no maintenance fees, and no sales charges or broker commissions. You pay only a low annual management fee of less than one percent.

It's easy to enroll.
Don't worry about a big up-front financial commitment. You can open an account for as little as $25 per contribution. And the Path2College 529 Plan offers an Automatic Contribution Plan that drafts your checking or savings account, or you can sign-up for the payroll deduction program and contribute as little as $15 per pay period. Once you start, it's easy to stay on track!

You can obtain enrollment, ACP, and payroll deduction information by contacting the state office of the Path2College 529 Plan at (404) 463-0000 or outside metro-Atlanta at (866) 529-9529 or by email at GA529@otfs.ga.gov. You can also obtain the necessary payroll forms by visiting www.otfs.ga.gov. Click on GHESP Forms and Information and review the Employee Payroll Checklist for New Accounts (if you do not currently have an account), or the Employee Payroll Checklist for Existing Accounts (if you already have an account). And visit www.path2college.com for more information.

Please note: Payroll contributions are made using after-tax dollars; therefore, you are not subject to the limits and restrictions for flexible benefits during the annual Open Enrollment period. Your payroll deduction can be started, stopped, increased or decreased at anytime during the year by contacting us at the numbers above.

Benefit Phone Directory

	Call if you have a question about how the plan works	Call if you have a question about a claim that has been submitted
Flexible Benefits Program		
Employee, Spouse, Child Life Insurance and Accidental Death and Dismemberment		
Life conversion and Portability information	404-656-2730 1-888-968-0490 or 1-800-660-2519	1-800-660-2519
Dental Insurance		
CIGNA - *www.cigna.com*	1-800-642-5810	
United Concordia-Regular & PPO *www.ucci.com/tuctcc/clients.jsp?id=18*	1-866-215-2356	
Vision Coverage *www.myoptumhealthvision.com*	1-800-638-3120	
Disability Insurance	1-888-641-7186	
Long-Term Care Insurance	1-888-SOG-FLEX or 1-888-764-3539	
Legal Insurance	1-800-848-2012	
Hearing Impaired *www.signaturelegalcare.com*	1-800-535-2348	
Spending Accounts	1-800-893-0763	
Hearing Impaired *www.shps.net*	1-800-952-0450	
Specified Illness Insurance	1-866-849-2958	
Portability Information *www.gms-specifiedillness.com*	1-866-849-2958	
State Health Benefit Plans		
SHBP Eligibility	1-800-610-1863 404-656-6322	
United Healthcare of Georgia		
Active Employees		
Health Reimbursement Arrangement - HRA	1-800-396-6515	
High Deductible Health Plan - HDHP	1-877-246-4195	
Preferred Provider Organization - PPO	1-877-246-4189	
Health Maintenance Organization - HMO	1-866-527-9599	
Retirees	1-877-246-4190	
CIGNA Healthcare		
Active Employees	1-800-633-8519	
Retirees	1-800-942-6724	
Kaiser Permanente		
Active Members	1-800-611-1811	

EMPLOYEE CHECKLIST

❑ Check with personnel/payroll office for deadlines.

❑ Review the enrollment booklet, providing you with valuable information for each option descriptions of required supplemental for medical underwriting requirements (page 11, and Terms & Conditions (inside front cover).

❑ During the 2009 Open Enrollment, make your benefit selections on the web site (http://team.georgia.gov/flex) from October 10 - November 10.

❑ Check Option Statement and enrollment booklet to confirm if forms are required, such as Medical Underwriting forms.

❑ Review your Confirmation Statement thoroughly and immediately report discrepancies to personnel/payroll office. Follow-up to assure corrections were made.

❑ Compare your December pay stub(s) against options selected. Contact your personnel/payroll office with discrepancies.

Report any incorrect information to your personnel/ payroll office.

Check the following forms that you need to complete and contact personnel/payroll office for forms:

❑ "Flexible Benefits Program Beneficiary Election Form"

❑ Minnesota Life "Evidence of Insurability Form" For Employee Life
For Spouse Life
For Child Life

❑ AIG "Evidence of Insurability Form"
For Specified Illness

❑ The Standard "Evidence of Insurability Form"
For Long-Term Disability

❑ Prepaid Dental Option "Dental Selection Form" (call CIGNA at 1-800-642-5810).
Each member must be enrolled with a provider.

❑ HSA Forms

For questions about claims or benefits for the State Health Benefit Plan, see page **Benefit Phone Directory** for phone numbers.

For general questions about the Flexible Benefits Program, call 404-656-2730 if it's a local Atlanta call, or toll-free at 1-888-968-0490 outside the local area.

The Flexible Benefits Program attempts to be as consistent as possible with State Health Benefit Plan rules and regulations. This is not always possible due to the variations in benefit offerings.

This booklet summarizes the benefits you can choose through the State of Georgia Flexible Benefits Program. A more detailed explanation of benefit provisions is provided in each benefit plan description. Every attempt has been made to ensure that the information in this booklet is accurate.

The State of Georgia Flexible Benefits Program is governed by legal documentation and insurance contracts. However, in the event there are any conflicts between this booklet and the official plan descriptions and contracts, the terms of the official plan descriptions and contracts will prevail.

The Flexible Benefits Program is governed by the current tax law and is subject to and operated in accordance with the regulations of the Internal Revenue Service (IRS). If changes in the Program are necessary to comply with the law or IRS regulations, you will be notified.

PRIVACY AND SECURITY NOTICE

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that covered entities, including state agencies that deal with Protected Health Information (PHI), provide you with this notice. This notice pertains to those programs specifically administered by the State Personnel Administration (SPA) in which SPA may maintain various types of PHI about you. SPA understands that information about you and your family is very personal. As such, SPA is committed to protecting and securing your information.

This notice tells you how SPA uses and discloses information about you and discusses your rights in keeping this information private and secure. Please review this notice carefully.

Overview

What is HIPAA?

HIPAA, the Health Insurance Portability and Accountability Act of 1996, is a federal law regarding the confidentiality and security of Protected Health Information (PHI). It imposes restrictions on how your health information can be used and shared and confirms rights for individuals concerning their own health information.

What is PHI?

PHI, Protected Health Information, is individually identifiable health information that is maintained or transmitted by a covered entity. It is information related to a person's health, provision of care, or payment. Examples of items containing PHI include: a bill for health services, an explanation of benefits statement, receipts for reimbursement from a health flexible spending account or any list showing the amount of benefits paid with a breakdown by social security number. This also includes your employer (state agency, school system, authority, etc.) transmitting information about you to SPA. This information may include your name, address, birth date, social security number, employee identification number and certain health information

How SPA Uses and Discloses Protected Health Information

When services are contracted, SPA may disclose some or all of your information to the company to perform the job SPA has contracted with them to do. SPA requires the company to safeguard your information in accordance with federal and state law.

Privacy and Security Law Requirements

SPA is required by law to:

•Maintain the privacy of your information.

•Protect electronic PHI by implementing reasonable and appropriate physical administrative and technical safeguards.

•Provide this notice of SPA's legal duties and privacy and security practices regarding the information that SPA has about you.

•Abide by the terms of this notice.

•Refrain from using or disclosing any information about you without your written permission, except for the reasons given in this notice. You may revoke your permission at any time, in writing. That revocation will not apply to information that SPA disclosed prior to receiving your written request. If you are unable to give your permission due to an emergency, SPA may release information, if it is in your best interest. SPA must notify you as soon as possible after releasing the information.

Your Health Information Rights

You have the following rights regarding the health information maintained by SPA about you:

•You have the right to see and obtain a copy of your health information. This right would not extend to information needed for a legal action relating to SPA.

•You have the right to ask SPA to change health information that is incorrect or incomplete. SPA may deny your request under certain circumstances or request additional documentation.

•You have the right to request a list of the disclosures that SPA has made of your health information beginning in April 2003.

•You have the right to request a restriction on certain uses or disclosures of your health information. SPA is not required to agree with your request.

•You have the right to request that SPA communicate with you about your health in a way or at a location that will help you keep your information confidential.

•You may request another copy of this notice from SPA, or you may obtain a copy from the SPA web site, **www.spa.ga.gov** (under "Privacy").

For More Information and To Report a Problem

If you have questions and would like additional information about Protected Health Information (PHI) you may contact the SPA Privacy Officer at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area). You may also visit SPA web site, **www.spa.ga.gov.**

SPA does not discriminate on the basis of disability in the admission or access to, or treatment of employment in its programs or activities. If you have a disability and need additional accommodations to participate in any SPA programs, please contact the SPA at the numbers listed. For TDD relay service only: 1-800-255-0056 (text-telephone) or 1-800-255-0135 (voice).

If you believe your privacy or security rights have been violated:

•You may file a complaint by calling the SPA Privacy Unit at 404-656-2730 (Atlanta calling area) or 1-888-968-0490 (outside of Atlanta calling area), or by writing to:

State Personnel Administration
Attn: Privacy Officer
2 MLK Jr. Drive, SE
Suite 502, West Tower
Atlanta, GA 30334

•You can file a complaint with the Secretary of Health and Human Services by writing to: Secretary of Health and Human Services, 200 Independence Ave. SW, Washington, DC 20201. For additional information, call 1-877-696-6775.

•You may file a grievance with the United States Office for Civil Rights by calling 1-866-OCR-PRIV (1-866-627-7748) or 1-886-788-4989 TTY.

There will be no retaliation for filing a complaint or grievance.

If SPA changes its privacy or security practices significantly, SPA will post the new notice on its web site at **www.spa.ga.gov** (Under "Privacy"). This notice, effective April 14, 2003, was amended April 20, 2005.